DOCUMENT RESUME

ED 097 880 IR 001 242

AUTHOR	Larsen, Judith K.; And Others
TITLE	Diffusion of Innovations Among Community Mental Health Centers. Final Report.
INSTITUTION	American Institutes for Research in the Behavioral Sciences, Palo Alto, Calif.
SPONS AGENCY	National Inst. of Mental Health (DHEW), Rockville, Md.
REPORT NO	AIR-29800; AIR-38100-8-74-FR
PUB DATE	Aug 74
NOTE	221p.
EDRS PRICE	MF-$0.75 HC-$5.40 PLUS POSTAGE
DESCRIPTORS	Community Health; *Diffusion; Experiments; Information Dissemination; *Innovation; *Mental Health Clinics; Mental Health Programs

ABSTRACT

An information diffusion system was designed and tested that would facilitate the diffusion of innovations on a national scale among community mental health centers. The experimental design used both written and interpersonal techniques. Combinations of the techniques were applied to three treatment groups and a control group. In addition, a number of data collection instruments were designed to assess the effectiveness of diffusion techniques. The results indicate that staff reactions to all three diffusion techniques were extremely positive. When the staff was asked to indicate their preference regarding diffusion techniques, 78.7 percent preferred interpersonal techniques, 19.2 percent preferred written techniques, and 2.1 percent cited other techniques. Moreover, requests from centers and other human service agencies for written materials far exceeded original estimates. Furthermore, feedback indicated staff would like the network to be continued and expanded. (Author/WCM)

AIR-29800 and 38100-8/74-FR

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AMERICAN INSTITUTES FOR RESEARCH

SOCIAL AND EDUCATIONAL RESEARCH PROGRAM

ED 097880

DIFFUSION OF INNOVATIONS
AMONG
COMMUNITY MENTAL HEALTH CENTERS

Section I: Final Report

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U.S. DEPARTMENT OF HEALTH,
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This study was supported in whole by the United States Public Health Service, Research Grant No. 1 R12 MH21215 from the National Institute of Mental Health

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ABSTRACT

Background

Every year many research and development projects are conducted with the goal of improving mental health services. Many of these projects are successful in designing new approaches or techniques, yet often these results are reported only in formal reports and rarely make their way back to actual practice. This project attempted to design and demonstrate an information diffusion system that would facilitate the diffusion of innovations on a national scale among community mental health centers. The project included a study of diffusion techniques and recommendations for a continuing diffusion network.

Design

The project was designed to investigate the diffusion of innovations by using both written and interpersonal techniques. Written materials consisted of the Source Book of Programs and Planning for Change: interpersonal methods included two components, site visits by staff to observe programs elsewhere and consultant visits. At a later stage in the project, another written technique was designed on a trial basis, Innovations magazine presenting highlights of evolving mental health services. Combinations of these techniques were applied to three treatment groups and a control group. The groups and their components were as follows:

1. Experimental Treatment Group A received the assistance of a consultant/change agent; expense-paid site visits for center staff to observe programs elsewhere; and the written materials, Source Book of Programs and Planning for Change.

2. Experimental Treatment Group B received expense-paid site visits for staff and the Source Book of Programs and Planning for Change. Centers in Group B did not receive consultant visits.

3. Experimental Treatment Group C received the Source Book of Programs and Planning for Change. This group received no interpersonal methods of information dissemination.

4. A Control Group received neither written nor interpersonal information.

A number of data collection instruments were designed to assess the effectiveness of diffusion techniques: a pre-treatment questionnaire to gather baseline data, a post-treatment (short-term) questionnaire to measure the more immediate effects of the treatment, a post-treatment (long-term) questionnaire to measure more long-lasting results. In the centers receiving consultant visits, additional

instruments included a questionnaire gathering the consultants' judgments regarding the consultation, project staff judgments of the consultation, and report forms containing demographic and programmatic information gathered at each center. Center staff reactions to the consultation were gathered on post-treatment questionnaires. In the case of centers receiving site visits, each visitor was asked to complete a Site Visit Reaction Form.

Results

Staff reactions to all three diffusion techniques were extremely positive. Of those making a judgment on the post-treatment (long-term) questionnaire, 86 percent felt the consultant's visit was useful to some degree, 94 percent felt the site visit was useful to some degree, and 91 percent felt the Source Book was useful to some degree. When comparing treatment groups on the mean number of innovations considered, there were non-significant increases for groups receiving interpersonal techniques and the control group, and a decrease for the group receiving written techniques. When staff were asked to indicate their preference regarding diffusion techniques, 78.7 percent preferred interpersonal techniques, 19.2 percent preferred written techniques, and 2.1 percent cited other techniques.

Implications

Community mental health centers are interested in establishing a system of information exchange. Response to the services offered by the project indicates centers are interested in an information diffusion system. Requests from centers and other human service agencies for written materials far exceeded original estimates. There were also unsolicited requests from centers for consultants, site visits, and other forms of assistance. Personal interviews, questionnaire data and letters all reported widespread agreement among such groups as center staff, national professional organizations, consultants, state and university training staff, and state and regional mental health service administrators for a useful system of information diffusion.

However, it is also clear that information diffusion cannot be taken for granted. Staff who have information to share are often unaware of diffusion networks and how to tap into them, and thus the information may not find a proper audience. However, when innovators were contacted and invited to submit information for widespread diffusion, the response indicated that staff are willing to provide and share information, as long as the diffusion channels are readily accessible and easy to use.

The comparison of alternate diffusion techniques revealed no significant differences in their effects on the criteria of number of innovations considered. However, staff reactions were highly favorable to most of the diffusion techniques and feedback indicated staff would like the network to be continued and expanded.

ACKNOWLEDGEMENTS

The authors acknowledge with thanks all those who aided in the planning and execution of this project, and those who cooperated by responding to our questions both in interviews and via the questionnaires. We express our appreciation not only for completing the questionnaires but also for the additional comments which many included, and which were a great help to us. We also extend our thanks to the centers which we visited and to the staff whom we interviewed. Their cooperation was apparent and appreciated.

We have greatly appreciated the special assistance of NIMH throughout this project, especially the contributions made by Dr. Howard R. Davis and Susan Salasin.

The National Council of Community Mental Health Centers, through Jonas Morris, Executive Director, and members of the Executive Committee, has provided invaluable assistance and advice.

We thank those from AIR who have contributed time and ideas to this project: Dr. William Shanner, Dr. Vincent Campbell, Barbara Sanderson, Angie Jacobs, Ron Stout, and Wendy Bartlett. Special thanks are given to Virginia David for typing many drafts of this report as well as keeping track of all other project activities, and to Alice Cherveny for administrative support.

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I. INTRODUCTION

A major invention of our century was recorded on December 23, 1947 -- the transistor. In the 27 years since that discovery, the impact made by the transistor has been immeasurable. Today it affects nearly every consumer, manufacturer, governmental agency, country and international body. Its phenomenal success captures one's curiosity. How did this invention -- one of thousands made over the last decade -- come to have such an effect? What contributions fostered it? How did it happen?

Theories and concepts behind the invention of the transistor originated in the 1920s in Europe. Ideas were "proposed, debated, and tested by an international group of physicists who traveled from one university to another to exchange ideas and communicate the results of recent research. Their mobility was aided in a major way by . . . international fellowships from the Rockefeller Foundation. These fellowships provided modest travel funds and stipends, thus enabling the bright young physicists of the period to come together with colleagues for the face-to-face discussions that are so crucial at a time when new ideas are brewing" (Weiner, 1973, p. 26).

A second major influence was the Bell System Technical Journal, which grew out of one man's habit of typing up reports of what he had heard at meetings of The American Physical Society. "The Bell System Technical Journal served a badly needed function and also helped to increase the mobility of talented physicists within the overlapping domains of academic and industrial research" (Weiner, 1973, p. 27).

The inventors of the transistor, John Bardeen, Walter Brattain and William Shockley, later recounted some of the influences that had directly facilitated their discovery. During an informal ceremony at Bell Laboratories in 1956 held to celebrate the Nobel Prize, Bardeen recalled that "it was a rather small group but it was a very closely knit group with frequent meetings and opportunities to exchange ideas." Brattain's reactions to the discussions were similar. "I cannot overemphasize the rapport of this group. We would meet together to discuss important steps almost on the moment of an afternoon. We would discuss things freely, one person's remarks suggesting an idea to another. We went to the heart of many things during the existence of this group." Bardeen also stresses the importance of the close ties that were maintained with other groups at Bell, to whom they would go for advice as well as for the materials that were so vital to their research (Weiner, 1973, p. 31).

In retrospect the innovative process seems to have had three critical elements: (1) written exchange of ideas and information; (2) personal visits allowing direct observation, participation and stimulation; and (3) an atmosphere of rapport and cooperative communication both within the organization and with external sources.

2

The example of the diffused transistor is taken from quantum physics and electrical engineering, but the process through which the innovation was disseminated and utilized should also be relevant to other fields. Confronted with major social problems and the need to resolve them, American Institutes for Research (AIR) and the National Institute of Mental Health (NIMH) collaborated to study ways of facilitating the diffusion and utilization of innovations in one particular setting--community mental health centers. This report is an account of that project.

The project was concerned both with the diffusion of innovative information and the use of that information. It was designed to study the process and relative benefit of those factors identified as related to innovation. As in the case of the transistor, these factors included publications and personal interaction; publications and written materials were directed specifically toward staff of community mental health centers, personal site visits allowed staff of one center to observe and participate in programs elsewhere, and the use of consultants encouraged an atmosphere conducive to change and innovation within a center. By studying these techniques both singly and in combination with one another, it is possible to make recommendations as to the relative advantage and impact for each in the field of mental health.

This report explains the procedures and techniques used in the project as well as results. Chapter II, Background, relates this project to previous research. Chapter III, Hypotheses, recounts the beliefs and assumptions underlying the project. It also lists the hypotheses forming the basis of research questions addressed by this study. Chapter IV provides information on design, methodology, evaluation techniques and data collection. Chapters V, VI and VII provide specific information on procedures used with each main diffusion component as well as results on the effectiveness of that component. Chapter VIII compares the effectiveness of treatment components among groups. It also suggests how characteristics of centers relate to readiness for change. Chapter IX describes the study of staff attitudes toward change. Chapter X explains the development and publication of Innovations magazine, a periodical designed to transmit information on mental health services to potential users. Chapter XI includes a summary and suggests recommendations for further research.

II. BACKGROUND

Diffusion and utilization of information contains elements of many disciplines and areas of expertise. To gain the benefit of previous research and investigation, a selective literature search was conducted in areas which were germane to the change process. One of the initial findings was the repeated documentation of interest in change and innovation. "A radical speeding up of the tempo of change is at the heart of the twentieth-century experience and has gained a powerful grip on the modern mind" (Gardner, 1964, p. 6). "Today's society is no longer stable, and technology does not change slowly" (Woods, 1971, p. 12).

There can be little doubt that the pace of modern society and the attendant demand for innovation, invention, renewal and updating are strong influences in every field: mental health, medicine, social systems, science, business and government. And not only innovation but also dissemination mirrors this changing society. "Basically, the worth of any new idea rests in its dissemination and utilization. The development of one well-planned day-care center model is of little relevance to society unless the design is publicized and used appropriately in a multitude of settings. We can think of dissemination as both importing new practices from outside the community or agency and as spreading significant practices from one worker to another within the community or agency" (Joint Commission on Mental Health of Children, 1973).

Along with this concern about change and dissemination has come an increase in the amount of information relating to change, innovation, and development. More than two million scientific articles are printed each year with an annual growth rate of about seven percent (Harley, 1968). Rogers in his pioneering volume Diffusion of Innovations published in 1962 covered some 400 citations; the second edition, Communication of Innovations, dated 1971, includes over 1,500 references. He comments that "not only have the number of publications increased, but the nature of diffusion studies has become much more varied. Diffusion studies are appearing in such fields as anthropology, agriculture, education, medicine, communication, marketing, and psychology" (Rogers, 1971).

The increase of diffusion studies has only compounded the problem of usefulness of journal articles and research reports. Schmuck (1967) states, "perhaps the most traditional and least successful mechanism for research utilization in education is the professional research journal. It is likely that most educators do not read the behavioral science journals. Indeed, behavioral research articles usually are not written in understandable ways from the point of view of the administrator. Information coded in a form understandable to the scientist often is only useful among the researchers using a similar language code."

The rift between research studies and utilization is evident in research reports as well as journal articles. "A large percentage of research reports have little significance in terms of direct utilization. A good deal of winnowing of the literature needs to be done. Even where research reports contain material that can be utilized in operating programs, persons in service agencies often find it hard to see the practical implications. Researchers generally address themselves to an audience of other researchers or to the administrators and trustees of the foundations which have supported their research. In many instances, researchers are insufficiently motivated or unprepared to attempt to interpret their findings in terms useful for program implementation" (Halpert, 1969).

As a result of this problem, there recently has been increasing concern for getting research results back to the practitioner. One alternative is the computer based retreival systems. The drawback to these systems is that while they may be beneficial to scholars or researchers familiar with lists of descriptors and retrieval techniques, the vast majority of practitioners do not avail themselves of the services. Roberts & Larsen (1971) report that two-thirds of state hospital libraries subscribe to the MEDLARS reference service, yet only 24.7 percent have used the service five or more times in the past year. If it is the same people who recommend an improved reference service who also do not avail themselves of MEDLARS, either the system is inadequate or the innovators are unaware of its value.

It may well be that the computerized retrieval systems are not inadequate, but that the premise underlying their existence is faulty, at least as it affects the local practitioner. Halpert (1969) observes that people who operate programs frequently do not have time to read the literature extensively enough to pick up new findings--doers are not readers. Practitioners often find it easier to learn by looking, listening and talking than by reading. The National Academy of Sciences in a report on Scientific and Technical Communication (1959) states "because it is user directed, interpersonal communication is one of the most effective means of 'translating' research findings into the contexts and terminology of those who can apply them and of bringing to the attention of a potential information user information applicable to his work but originating in subject areas in which he generally would not search." Roberts & Larsen (1971) found that the majority of persons who attempt to initiate improved mental health care practices get their ideas from the work or experience of others; 74.7 percent report that their ideas come from outside sources. What sources? In a 22-choice question concerning the primary source of the innovative idea, personal contact of one kind or another was selected by an overwhelming portion (83.5 percent) of innovators.

The Department of Agriculture was an early pioneer in the use of personal contact with their county extension agents in the 1920s. Since then information dissemination by personal contact has spread to many other disciplines. Glaser & Coffey (1967) reporting on dissemination in vocation rehabilitation, suggest that since face-to-face communication, where questions can be asked and comments made seems always to be best, conferences combined with trips to other agencies should be encouraged. Personal contact with the innovators may well be a crucial condition for the optimal dissemination of new ideas. One effect of the personal contact is simply the support and encouragement which it gives to the agency.

The value of visits and conferences in education has been documented by the System Development Corporation's (SDC) traveling seminar and conference. Richland (1965) reports that SDC provided educators with visits to the sites of educational innovation and found that the traveling seminar and conference, a field service concept, is a highly effective dissemination method for stimulating and facilitating educational innovation.

Interpersonal communication has an impact not only on actual implementation of innovations but on staff attitudes as well. "Some agencies cannot be innovative because, in a manner of speaking, they don't know better. Respondents from several agencies--especially those in rural areas, sparsely populated states or regions otherwise removed from the population centers--expressed feelings of being isolated and out of touch with what was going on in the field . . . . Respondents from target agencies who appeared knowledgeable described ongoing, institutionally financed activities such as site visits to innovative programs by staff, consultation visits to innovative programs by staff, consultation visits from innovators and regular staff seminars to discuss new developments. For example, one agency funded a year-long series of consultation visits based upon a theme chosen by the staff. The benefit of such a program is not necessarily direct adoption of an innovation. . . . The stimulating and vitalizing benefits derived from active dissemination and education programs appear considerable, even in the absence of specific utilization" (Glaser & Ross, 1971, p. 90).

At this point a word of caution must be sounded. Personal contact, while important, is not the only answer. Roberts & Larsen (1971) found that although personal contacts were of most value in initiating ideas, they were not the sole source of information used in later planning and development. Almost half (45 percent) of innovators use journals or books at some stage in their preparations. Given this evidence, it seemed necessary to include both types of information dissemination--written and personal--in the project.

Unfortunately, no kind of written or interpersonal dissemination techniques will insure that potential users of promising innovations will gain sufficient information about them to consider using them or, even with sufficient information, to adopt them. These methods undoubtedly help, but research has shown (Havelock, 1971, 1973; Rogers, 1971; Klonglan & Coward, 1970; and Glaser & Ross, 1971) that the problem of diffusion and utilization of innovative practices requires far more complex solutions.

Klonglan & Coward (1970) for example, have developed a model which illustrates that the awareness of an innovative idea is only an initial step in the adoption process. After awareness, it is necessary to gather information, make an evaluation and then respond with symbolic rejection or symbolic adoption. If symbolic adoption is accepted, the innovation is next put through a trial phase which leads to trial rejection or trial acceptance. Only after trial acceptance is the innovation finally considered to be adopted. Although the above explanation is simplistically linear, the authors recognize the interactive effect on decision making of numerous sociological and economic variables.

Havelock (1971) from a review of the literature, poses three general models of diffusion and innovation: (1) the Research Development and Diffusion Perspective, (2) the Social interaction Perspective, and (3) the Problem Solver Perspective. The first, the Research Development and Diffusion Perspective, "posits a user population which can be reached effectively and influenced through a process of 'dissemination,' or by dissemination activities of various sorts, provided, however, that this dissemination is preceded by an extensive and complex process of research and development which usually includes the following features: basic research, applied research, development, production and packaging." This general method is used by industry as well as by the U. S. Agricultural Research and Extension System.

The second model, the Social Interaction Perspective, concerns itself primarily with an analysis of the diffusion process. Proponents of this approach "assume the existence of a diffusable innovation" and then concentrate on "measuring its flow through a social system over time." This method has been used by sociologists to study the diffusion of innovations in farm practices and the spread of new drugs among physicians.

Finally, the Problem Solver Perspective "rests on the primary assumption that knowledge utilization is a part, and only a part, of a problem solving process inside the user which begins with a need and ends with the satisfaction of that need." This perspective "is closely associated with the human relations tradition of planned change and it represents basically a psychological and 'user oriented' approach to problems of diffusion and utilization." The mental health consultation used in this project most closely approximates this approach.

These three models each respond to certain needs but ignore others. Therefore Havelock & Havelock (1973, p. 23) suggest a summative model, namely the Linkage Process. "The user experiences an initial felt need which leads him to make a diagnosis and a problem statement. He then works through search and retrieval phases to a solution, and finally to the application of that solution."

Rogers (1971) suggests four stages in his present model of the innovation-decision process: (1) knowledge -- the individual gains some understanding of the innovation, (2) persuasion -- the individual forms a favorable or unfavorable attitude toward it, (3) decision -- the individual chooses to adopt or reject the innovation, and (4) confirmation -- the individual seeks reinforcement for his decision.

In a recent field study, Glaser & Ross (1971) derived implications for strategies which included (1) screening of potential users in terms of the inherent characteristics of a given innovation that relate to its acceptability by the user, (2) identification of potential user barriers to the innovation and development of ways to reduce barriers inherent in the innovation, (3) preparation of dissemination materials which are responsive to user needs, (4) further selection of potential users in terms of their reaction to the desirability of the specific innovation and in terms of the users' innovative potential, and (5) providing to the final target group opportunities for more direct contact with and knowledge of the innovation by site visits, conferences, seminars, consultants, etc. The authors note that these suggestions are not meant to be a formula for a dissemination strategy. Rather they indicate a procedure that can be used in planning. Effective dissemination strategies cannot exist as formulas in the abstract; their elements must correspond to particular characteristics of innovations and target agencies.

Davis (1973) has developed a behaviorally-based model of change which suggests a four-step approach: Analysis, Goal Definition, Action and Follow-Through. The Analysis and Action stages make use of guidelines developed from the A VICTORY model. This is the acronym used to present the eight factors determining program performance or change. The factors are:

A Ability - Required program resources--fiscal, spatial, manpower, skills.
V Values - Characteristics of the organization, key staff, specific client.
I Information - Available solutions, how produced, how communicated.
C Circumstances - Relevant environmental characteristics or happenings.
T Timing - Crises, cycles, pertinent events coming up.
O Obligation - Felt needs, motivation to do something about them.
R Resistances - Objections, rational and irrational, to performance approach.
Y Yield - Payoff of the performance or change, including personal rewards.

There will undoubtedly be interaction and overlapping among factors. But the importance in considering them lies in the evidence that determined efforts can fail, or at least achieve less if any one of the factors is neglected.

Goal definition is somewhat less flexible and entails a clear understanding of what is expected. One technique that can be used to aid in defining goals is Goal Attainment Scaling. Through the device of standard scores one is able to compare effectiveness of one goal with another. In the Follow-Through phase there is an essential mental set to maintain: even with the best of efforts, innovative solutions may look as if they are foundering. Continued effort is necessary to maintain past gains.

Given the research evidence supporting the efficacy of personal contact, a major component of this project was the use of consultants to facilitate interpersonal communication. They were to act as "change agents" or "facilitators" or "dissemination and utilization experts," and were to assist community mental health centers in considering the change process.

The literature overflows with suggestions, advice, techniques and guidelines for consultants and change agents. Most authors recommend that the role of change agent be defined as facilitator and catalyst rather than an expert well acquainted with innovations in one specific area (Havelock, 1971; Jung, 1967, p. 90-91; National Institute of Mental Health). This project followed these recommendations and focused on the consultant/change agent as one concerned with the change process as a whole. The primary concern of this project was introducing a long-term approach to change rather than helping the center find "the" answer to one specific problem. As Rogers (1971) explains, the change agent should seek to raise his client's technical competence and ability to evaluate potential innovations. Then eventually the clients could become their own change agents. Self-reliance and self-reviewing behaviors should be the goal of planned change programs.

The use of an external change agent poses both advantages and hindrances. Certainly a disadvantage is the transitory nature of the agent's presence and influence, coupled with a general lack of power for effecting change in a foreign system. The advantage is the unbiased and fresh analysis of the center's situation.

The "homophily" of change agents, i.e., the more alike two people are, the more likely they are to influence each other, can be a critical variable. Change agents are most successful when interacting with people who have similar characteristics-- social status, ethnic background, sex, income level, education. The credibility of the change agent is another crucial variable. "If a client perceives that a change agent possesses relatively higher credibility than various other sources and channels, the client will be more receptive to messages from the change agent" (Rogers, 1971, p. 237).

It is imperative that the change agent be skilled as a consultant and in working with people. Without this ability, the expectancy for a successful consultation is bleak. Therefore people were located who were trained as consultants and had a record of successful experience. Project orientation was limited to information appropriate to the role of change agent. (See page 22 for additional information on the orientation of the change agents.)

Written materials, site visits and assistance from consultants-- all are legitimate and valid forms of information diffusion. However diffusion, while necessary, is not a sufficient condition for promoting social change. Such change depends on staff attitudes and agency and environmental characteristics. These variables and their relationship to innovation as found in this project, are described further in later chapters of this report.

III. HYPOTHESES

When comparing and studying diffusion techniques, the central concern is which technique or combination of techniques is most effective. Previous research and the literature indicate that some techniques seem to be more effective in a variety of situations than others. For example, personal contact with colleagues generally has been found to be a preferred diffusion technique. The concern in this study was what techniques are most effective for information diffusion in a select audience -- namely, community mental health centers. The techniques selected for investigation were techniques which could be readily used with the target audience. They were well within the scope of NIMH activity and had been used previously, either in part or whole. These techniques were selected as being representative of a broad range of diffusion methodologies.

Diffusion techniques concentrate on getting information out to an audience. However once that is accomplished, the related question of information utilization arises. How is the information used? Does it result in changes in the organization and if so, what kind? Are procedures developed for considering proposed changes and determining what course of action to take? Are some organizations or individuals more likely to consider new information and change than others, and what are their characteristics?

The purpose of this study was to focus on the first issue, diffusion techniques, as they related to change in community mental health centers. Attention was devoted to the change process per se whenever possible, but this was secondary to the investigation of methods of information diffusion. The following hypotheses formed the basis for study.

1. Interpersonal diffusion techniques are more effective for initiating ideas among staff in community mental health centers than written diffusion techniques.

Personal contact, including the opportunity for observation, discussion and asking specific questions, is more likely to result in innovation than reading, where the action is more passive and usually not responsive to specific concerns.

2. A combination of several interpersonal and written diffusion techniques are more likely to lead to innovation than any one independent technique.

Centers receiving information via three diffusion channels have more potential innovations presented to them and therefore are more likely to find new ideas suitable for adoption. Centers receiving information from two sources are aware of fewer innovations and may be less likely to consider an innovation for potential adoption. Centers receiving information from only one source have the least amount of information and will report the fewest innovations considered.

3. Communication between a center and an outside resource (e.g., consultant, site visit) is more likely to result in innovation than communication and discussion limited to internal staff.

Centers in which staff have the opportunity to interact with a consultant or innovator who has already implemented a program are likely to consider implementing new techniques. Centers without any outside resource person will be more passive and less likely to implement new programs.

4. Centers which provide staff visits to other centers are more likely to consider innovations than centers which do not support such contact.

Direct observation is likely to be more influential than indirect reports. Centers which support such observation will be more open to considering change than centers which do not support such visits.

5. Centers which receive consultant visits are more likely to consider innovations than centers which do not receive such assistance.

Interaction with someone trained in change and innovation, and able to function as a group catalyst, will assist staff in establishing an orderly process for considering innovations. Therefore more innovations will be considered by these centers than by centers who have not received such assistance.

6. More favorable staff attitudes toward the change process are likely to result in more innovations being considered at the center.

If staff attitudes toward change are generally negative, few innovations will result. However if staff are aware of the change process and agree to the value of planning, more innovations will be considered.

7. The larger the center, the more innovations will be considered.

As a function of size, more staff are likely to have more ideas and thus consider more innovations.

8. The age of the center is likely to influence the number of innovations considered.

Newly established centers are likely to report more new ideas since nearly everything they do is new. This interest in change and innovation may then decrease with age of the center.

9. Location and ownership may influence the number of innovations considered.

Centers may vary in innovations reported depending on geographic location and ownership.

IV. METHOD

Procedures

The project was designed to investigate the diffusion of innovations by using both written and interpersonal techniques. Written materials consisted of the Source Book of Programs and Planning for Change; interpersonal methods included two components, site visits and consultant visits. With these variables it would be possible to design an elaborate study using many different combinations of treatments, controls and measures. However the realities of time, money and staff also speak loudly, and a compromise must be made between these practical limitations and experimental design. Therefore the project was limited to three treatment groups and a control group. The groups and their components were as follows:

1. Experimental Treatment Group A received the assistance of a consultant/change agent; expense-paid site visits for center staff to observe programs elsewhere; and the written materials, Source Book of Programs and Planning for Change.

2. Experimental Treatment Group B received expense-paid site visits for staff and the Source Book of Programs and Planning for Change. Centers in Group B did not receive consultant visits.

3. Experimental Treatment Group C received the Source Book of Programs and Planning for Change. This group received no interpersonal methods of information dissemination.

4. A Control Group received neither written nor interpersonal information.

Sampling

Since the project dealt with all community mental health centers in the United States, the first problem was selection of a representative sample. NIMH supplied a list of 437 community mental health centers, all of which had been approved for federal funding. This list formed the data base of the project. Some of these centers had been in existence for years (one had first opened in 1916); others had opened within the previous year or two; still others were in the planning stage and not yet open.

The following descriptive information was furnished for each of the centers:

(1) name and address of center
(2) name of director
(3) names of center components and services provided by each
(4) description of the center's catchment area

(5) geographical description of the population served (mixed, inner city, urban, suburban, scattered, rural, sparse)
(6) socio-economic description of the population served (percent under age 17, percent over age 65, percent nonwhite, catchment area population) and
(7) geographical location of the center (inner city, urban, suburban, rural)

Complete as this information was, a few questions were unanswered. Therefore the first contact with the centers was a questionnaire sent to the director of each center (see Appendix A). This questionnaire was designed to help determine which centers were open, to gather data to supplement information supplied by NIMH, to establish baseline criterion measures, and to obtain information on innovations. The additional descriptive data added to that previously supplied by NIMH was:

(1) date center opened
(2) full-time equivalent personnel
(3) number of people served each year
(4) general income level of district
(5) approximate budget

In any study of diffusion of innovations, the basic criterion measure is the number of innovations and information on their diffusion. Therefore the most important questions asked were:

(6) the number of innovations introduced during the previous two years, and
(7) the number of new practices planned

Finally we requested the following additional information:

(8) checklist of center concerns
(9) titles of new practices introduced during the previous two years and the name of a contact person for each

The response to the questionnaire to center directors (QD) was excellent. The exact rate of response is difficult to determine since the number of centers that are open and in operation changes constantly. We were supplied with names of 437 centers that had been approved for funding, and heard from 308, for an overall rate of 70 percent. Of these 308 centers, 260 agreed to participate and returned completed questionnaires, and 48 centers responded to our letter but were unable to participate. There were 129 centers that may or may not have been open but did not respond to the questionnaire.

There was now a pool of 260 centers which had responded to the questionnaire and were eligible and willing to participate. From this group, centers were assigned to one of the three treatment groups or to the control group. Since it was expected that some centers would drop out over the two-year period, especially from the minimum-intervention and control groups, the design called for two groups of alternates. Centers in these backup groups would receive the same treatment (or lack of it) as those in the original groups and could serve as replacements for the dropouts.

Many variables were considered as criteria for assigning centers to groups. Eventually seven were selected as being most important: (1) number of innovations considered, (2) size of center, (3) region of country, (4) age of center, (5) type of catchment area, (6) center ownership, and (7) income level of clients. The first three were selected as primary variables with the other four as secondary variables.

The following table shows the variables and their divisions:

Table 1

Selection Variables

Variable	Source
Primary	
1. Number of innovations considered* a. Few (5 or less) b. Many (6 or more)	Questionnaire to Director (QD)
2. Size of center a. Small b. Medium c. Large	Size was determined as a composite measure including staff size, number of clients served per year and annual budget.
3. Region of country a. East b. South c. Midwest d. West	Regions were roughly defined on the basis of NIMH regions.
Secondary	
4. Age of center a. Less than two years b. From 2 to 4 years c. Five or more years	Questionnaire to Director (QD)
5. Type of catchment area a. Inner city b. Urban c. Suburban d. Rural	NIMH information

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*Includes number of innovations introduced during previous two years and number of new practices planned.

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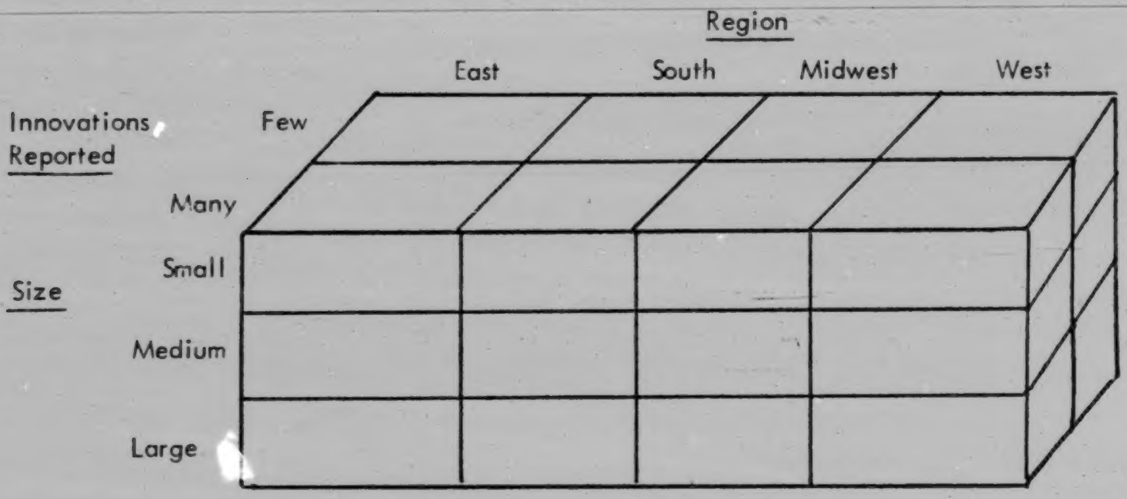
Table 1 (Continued)

Variable	Source
6. Center ownership a. Public b. Private	NIMH information
7. Income level of clients a. Low b. Low-middle c. Middle	NIMH information

A stratified random design based on the three primary variables was used in assigning centers to the four groups. On the basis of these criteria, 24 cells were formed: innovations (few, many) x center size (small, medium, large) x region (East, South, Midwest, West). See Figure 1 for an illustration of the design.

Figure 1

Sampling Design



In order to form the treatment and control groups, four centers were drawn at random from each cell and assigned, again at random, to each of the treatment and control groups. This procedure should have resulted in 24 centers per group; however the small number of centers in some cells precluded this.

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The final count per group was as follows: Treatment Group A (consultants, site visits, written materials), 23 centers; Treatment Group B (site visits, written materials), 23 centers; Treatment Group C (written materials), 21 centers; Control Group, 22 centers.

In addition, two groups of alternates were drawn to be used as replacements for centers which might drop out later. These alternates were selected after the other groups had been drawn, and were selected from the cells with the largest number of centers remaining. The alternates to Treatment Group C numbered 10; the alternates to the Control Group numbered 9. A third group of 11 "floating" alternates was also selected to be used only if needed.* Table 2 indicates the composition of the groups.

Table 2

Group Compositions

Treatment Group A

		South	East	Midwest	West	Total	
Small	Few Innov.	X	X	X	X	4	
	Many Innov.	X	X	X	X	4	8
Med.	Few Innov.	X	X	X	X	4	
	Many Innov.	X	X	X	X	4	8
Large	Few Innov.	Empty cell	X	X	X	3	
	Many Innov.	X	X	X	X	4	7
		5	6	6	6		23

Treatment Group B

		South	East	Midwest	West	Total	
Small	Few Innov.	X	Empty cell	X	X	3	
	Many Innov.	X	X	X	X	4	7
Med.	Few Innov.	X	X	X	X	4	
	Many Innov.	X	X	X	X	4	8
Large	Few Innov.	X	X	X	X	4	
	Many Innov.	X	X	X	X	4	8
		6	5	6	6		23

---

*No alternative groups were selected for Treatment Groups A and B. It was felt that these groups would be easier to monitor since personal contact was established and they were receiving a $500 travel stipend. It was also explained to centers in these two groups that one condition of accepting the stipend was that they agree to cooperate in the project evaluation. For the most part this assumption proved to be accurate.

Table 2 (Continued)

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Treatment Group C

		South	East	Midwest	West	Total	
Small	Few Innov.	X	X	X	X	4	
	Many Innov.	X	X	X	X	4	8
Med.	Few Innov.	X	X	X	X	4	
	Many Innov.	X	X	Empty cell	X	3	7
Large	Few Innov.	Empty cell	X	X	X	3	
	Many Innov.	X	X	Empty cell	X	3	6
		5	6	4	6		21

Control Group

		South	East	Midwest	West	Total	
Small	Few Innov.	X	X	X	X	4	
	Many Innov.	X	X	X	Empty cell	3	7
Med.	Few Innov.	X	X	X	X	4	
	Many Innov.	X	X	X	X	4	8
Large	Few Innov.	Empty cell	X	X	X	3	
	Many Innov.	X	X	X	X	4	7
		5	6	6	5		22

Alternates to Treatment Group C

		South	East	Midwest	West	Total	
Small	Few Innov.	Empty cell	Empty cell	X	X	2	
	Many Innov.	X	Empty cell	Empty cell	Empty cell	1	3
Med.	Few Innov.	Empty cell	X	X	Empty cell	2	
	Many Innov.	X	X	Empty cell	X	3	5
Large	Few Innov.	Empty cell	Empty cell	Empty cell	X	1	
	Many Innov.	Empty cell	X	Empty cell	Empty cell	1	2
		2	3	2	3		10

Table 2 (Continued)

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Alternates to Control Group

		South	East	Midwest	West	Total	
Small	Few Innov.	Empty cell	Empty cell	X	X	2	
	Many Innov.	X	Empty cell	Empty cell	Empty cell	1	3
Med.	Few Innov.	X	X	X	Empty cell	3	
	Many Innov.	Empty cell	Empty cell	Empty cell	X	1	4
Large	Few Innov.	Empty cell	Empty cell	Empty cell	X	1	
	Many Innov.	Empty cell	X	Empty cell	Empty cell	1	2
		2	2	2	3		9

"Floating" Alternates

		South	East	Midwest	West	Total	
Small	Few Innov.	X	Empty cell	X	X	3	
	Many Innov.	X	Empty cell	Empty cell	Empty cell	1	4
Med.	Few Innov.	X	Empty cell	Empty cell	X	2	
	Many Innov.	X	X	X	X	4	6
Large	Few Innov.	Empty cell	Empty cell	Empty cell	Empty cell	0	
	Many Innov.	Empty cell	X	Empty cell	Empty cell	1	1
		4	2	2	3		11

Evaluation Techniques

Since the project included the investigation of different dissemination techniques over time, it became necessary to plan two types of comparison measures--those that relate to changes over time and those that permit comparison of treatments at one given time. Three basic data collection instruments were designed: a pre-treatment questionnaire to gather baseline data, a post-treatment (short-term) questionnaire designed to measure the more immediate effects of the treatment, and a post-treatment (long-term) questionnaire measuring more long-lasting results. The pre-treatment questionnaire (Q1) was administered to all centers in both treatment and control groups. The post-treatment (short-term) questionnaire (Q2) was administered to treatment groups only. The questionnaire was distributed to Group A centers at the end of the consultant visit, to Group B centers at the completion of staff site visits, and to Group C centers immediately following reception of the written materials. Post-treatment (long-term) questionnaires (Q3) were administered to Groups A, B and C approximately six months after the treatment. These questionnaires are included as Appendices B, C, and D.

The project was concerned with the change process as it affected the total center. To obtain a representative response from center staff, questionnaires were mailed to several staff members at each center in addition to the director. In order for a center to be eligible for further participation, it was required that at least two completed questionnaires be returned per center. Actually most centers returned at least three or more completed questionnaires.

The items in each questionnaire were designed to measure specific staff attitudes toward the change process. These variables were: (1) staff willingness to consider change, (2) awareness of programs existing elsewhere, (3) staff involvement in the change process, and ultimately (4) the utilization of information.

These variables are only a sample of the many staff attitudes which might be selected for more thorough study. However these variables are representative of a range of attitudes and activities which provide an indication of staff reactions to change.

Staff willingness to consider change is a preliminary attitude necessary for successful implementation. Willingness involves attitudes not only toward the value of the proposed change, but also toward the adoption process itself.

Awareness of information about innovations which may be promising in fulfilling a center's needs is essential to the change process. Even though an organization may be inclined to consider and evaluate new practices, it needs adequate information before doing so.

Staff involvement in the change process is considered necessary to maximize the chances of success in planning and implementing new programs. Staff members whose activities would be most affected by the proposed practice should be involved from the first planning stages. Also the degree to which staff contribute to formulation of center policies and procedures provides a general indication of staff involvement.

Utilization describes the procedure of considering the information once it is available. In this project utilization was not equated with adoption. There are cases where information is considered and a decision is made against implementing an innovation. Such a decision may be sound and reasonable. There is little wisdom in change for the sake of change; in fact such activities are often counterproductive. For purposes of this project, utilization included investigation, evaluation, planning and trial use of information as well as actual implementation.

The items appearing in the questionnaires are the result of an extensive process of instrument testing and development. Originally several hundred items were prepared which related to the major variables. These were reviewed, critiqued, combined and eventually formed into a working paper containing 72 questions. A further refinement process then finally narrowed the list to 22 questions to be used in preliminary tryouts. A draft version of the pre-treatment questionnaire (Q1) was prepared and administered to staff members at several community mental health centers. Based on their responses and suggestions, the questionnaire was revised and presented to the project consultants for review. A sample of the final version of Q1 is included in Appendix B.

The evaluation measures described to this point were designed for administration to all groups regardless of treatment intervention in order to allow comparisons among groups. In addition to this technique, evaluation techniques were also planned to collect data specific to each intervention. In the case of consultant visits, this included: (1) a questionnaire gathering the consultant's judgment regarding the center and the consultation, (2) project staff judgments of the center and consultation, and (3) report forms containing extensive information on the center. Center staff were also asked for their judgments of the consultation on Q2 and Q3 sent to Group A centers. In the case of site visits, each visitor was asked to complete a Site Visit Reaction Form (QS).

V. PROCEDURES AND RESULTS: CONSULTANTS

Procedures

One of the basic questions the project investigated was the relative merit of written versus interpersonal techniques of information dissemination and of planning for change. Consultant visits and staff observation trips were the two aspects of the interpersonal communication component.

The use of consultants to assist centers in program planning and development was a major segment of the project. The role of the consultants has been described using a number of titles--change agent, research utilization specialist, linking expert, information broker. Regardless of title, the person needed to have skills in consultation and be generally knowledgeable about innovative mental health practices and the change process. These consultants were external to the facility receiving the consultation, offering the advantage of consultant independence and perspective but the disadvantage of not thoroughly knowing the program.

From the first planning sessions the National Council of Community Mental Health Centers (NCCMHC) worked closely with project staff in developing consultation services. Since all facilities receiving consultant visits would be community mental health centers, it seemed wise to follow the practice of homophily and select consultants who were similar in background to those receiving the consultation. The National Council had available a number of people trained to serve as consultants, who agreed to assist in this project.

Three main criteria were used in the selection of consultants. The first was previous knowledge of consultation skills. It was not the purpose of this project to conduct a basic training session in consultation; therefore, it was requested that the consultants had received training elsewhere and already possessed the requisite consultation skills. Secondly, the consultants should have experience in consultation. Since the task required considerable flexibility on the part of consultants, it was felt that persons who had a depth of experience would be better able to deal with the situations that might arise than those without a broad background. Thirdly, the consultants should have a knowledge of the change process and should have been involved with implementing change themselves.

NCCMHC recommended six consultants who came from a variety of backgrounds. In terms of academic discipline they represented social work (2), psychology (3), and psychiatry (1); geographically they were from the East (1), South (1), Midwest (2) and West (2). They were also varied in terms of ethnic group and approach to the consultation; they were more similar in age (30s and 40s) and in their involvement with mental health activities on a regional or national level.

From the time the consultants were first selected, they were regularly sent background information on the project and specifically on the consultation component. However, previous research and experience indicate that six different consultants will in all eventuality do six different things. Since the consultation component was set up as one unit, not six, it was important that these six meet together for an orientation session to attempt to standardize their approaches as much as possible. The orientation session was held in January 1973.

The purpose of the two-day session was to explain the design and objectives of the consultant visit and to introduce the materials prepared for the visit. The orientation session began with a discussion of the consultant's visit to the center. The goals of the visit were spelled out:

1. To help center staff develop an awareness of the change process
2. To encourage staff involvement in considering new programs
3. To assist centers in identifying their needs
4. To encourage centers to identify their resources and limitations
5. To suggest potential programs related to those needs, resources and limitations
6. To suggest future steps the center might take in considering and implementing change.

All visits were planned to be conducted in the same general manner--an initial meeting with the director, brief individual meetings with key staff, group meeting(s) of those same key individuals, and a feedback meeting with the director. Within that framework, consultants were free to employ their own preferred techniques. For purposes of comparison with other dissemination techniques, it was important that some of the same topics be discussed at each location, therefore interview checklists were prepared for use at each center. The consultant was instructed to be sure that the listed topics were covered at some point during the interview or session. A complete set of the checklists and other materials developed for the consultant visit are found in Appendix E.

The initial interview with the director was very important. Although several contacts had been made with each center by means of letters and phone conversations, invariably there was a need for clarification and explanation. It was important that the director realize the purpose of the consultant's visit and be willing to participate. The consultant discussed with the director what he planned to cover at the meetings, and received the director's approval. It was also important to know to what extent the director felt staff should participate in the decision-making process, and that he understand and support the basic approach of the consultant. The consultants were careful to make no attempt to undercut the director's style; rather the consultants attempted to work with the center--to vary techniques in order to meet the needs of the individual center--in considering the change process and how to handle change effectively in that location and under existing circumstances.

In an attempt to relieve the director of the details of arranging the visit, the suggestion was made that the director appoint a liaison person for the consultant visit if desirable. In centers where such a liaison person was appointed, an interview was also conducted with this person. These visits focused on administrative aspects of the site visits to be made by staff members in coming months.

Interviews with key staff were usually brief--approximately 30 minutes--and provided the consultant an opportunity to meet staff individually, explain the project and the visit, get staff input regarding needs, resources and limitations, and establish some rapport before the larger group meeting.

The group meetings were perhaps the central aspects of the visit. Two half-day group sessions were planned wherever possible, with the same people attending both meetings. At these meetings the consultant most often discussed change in the context of the situation at that center. It was also at these meetings that the variation in consultant style was most noticeable.

The visit concluded with a feedback session involving the director and other key staff that he may have included. The consultant summarized his observations and made recommendations on future steps the center might consider.

This was the general schedule; however it is doubtful that any visit occurred exactly as described. Each visit was arranged to accommodate the requests of the local center. For example, one center had a total staff of three, so the consultant conducted a 1-1/2 day group session. A rural center asked the consultant to visit the satellite center some 60 miles away to speak with staff there.

Each consultant was accompanied on each visit by a member of the project staff. The staff person took no part in the consultation per se, and participated in group discussions according to the preference of the individual consultant. In general the purpose of the staff person's visit was to collect information on the consultant's style and on the consultation component in general. This information would later be used in comparing various dissemination techniques.

A packet of information on each center was prepared for the consultant's use. The packet included demographic and background information on the center, a list of center concerns as described by the director, copies of all correspondence, and any miscellaneous information. Also included were the interview checklists, evaluation forms to be left with staff at the conclusion of the visit, and the consultant's reaction form to be completed after the visit. The center information packet was given to the consultant before the visit so it could be used in preparation.

Detailed information was collected on each visit and prepared in a series of 15 case studies. These case studies are found in Section II of this report.

Originally there were 23 centers in Treatment Group A that were eligible to receive consultant visits. Of these, six centers were eliminated when they failed to return the minimum number of questionnaires on the pre-treatment measure; one center had the consultant component explained by letter and phone and declared they did not care to receive a visit. At the time of the consultant orientation session there were 16 centers remaining in Treatment Group A; however, following the session one center changed its mind and withdrew. This left a final count of 15 centers. Unfortunately, one of the consultants was left in the position of having no center remaining on his schedule, so he withdrew from active participation at that point, leaving five consultants. Three of these consultants visited three centers, one person visited four, and one visited two.

Results

Staff reactions to the consultant's visit are based on two questions asked on both the post-treatment (short-term) questionnaire (Q2) and the post-treatment (long-term) questionnaire (Q3). One question asked for staff to rate the usefulness of the consultant's visit; the other asked for staff to describe the most and least useful aspects of the visit. On the post-treatment long-term questionnaire (Q3), respondents were also asked how the visit could be improved.

Table 3 reports staff reactions to the usefulness of the consultant's visit immediately after the visit (Q2) and six months later (Q3).

Table 3

Usefulness of Consultant's Visit

	Q2		Q3	
	N	%	N	%
Extremely useful	12	12	3	4
Very useful	35	34	10	13
Useful	30	29	27	36
Somewhat useful	13	13	20	27
Not at all useful	6	6	10	13
No response	6	6	5	7
Total	102	100%	75	100%

The effect of the consultant's visit dropped off over time. As can be seen from Table 3, the visit was rated more useful immediately following the consultation than six months later. According to Q2, 75 percent of the respondents rated the consultant's visit as useful, very useful, or extremely useful, whereas by Q3 this figure fell to 53 percent. Reasons for this decrease may be due to a smaller response six months later and to the fact that different staff may have responded to the questionnaire. However, it was anticipated that the effects of the two-day consultant's visit would be greater immediately following the visit.

Comments on the most and least useful aspects of the visit are reported in Tables 4 and 5 respectively. The responses are reported for both Q2 and Q3. Again, more comments were received on the short-term questionnaire. Of the 157 comments received on the short-term questionnaire, 78 percent were positive and 22 percent were negative. Eighty-nine comments were reported on the long-term questionnaire; 56 percent were positive and 44 percent were negative.

Table 4

Most Useful Aspects of Consultant's Visit

	Q2		Q3	
	N	% of 157	N	% of 89
Shared information	22	14	6	7
Provided feedback of center's programs	16	10	5	6
Fostered self-examination	15	10	6	7
Acted as a catalyst	10	6	9	10
Increased staff communication	13	8	4	4
Provided expertise	10	6	6	7
Stimulated discussion of change	8	5	4	4
Increased awareness	9	6	2	2
Discussed specific problem	5	3	2	2
Liked resources ($500)	6	4	-	-
Gave picture of national situation	3	2	1	-
Liked independent discussion with consultant	2	1	1	-
General positive	4	3	4	4
Total (positive)	123	78%	50	53%

The three most useful aspects of the consultant's visit as determined from total responses were: (1) the consultant shared information about programs at other centers; (2) the consultant provided feedback about the center's own program; and (3) the consultant fostered self-examination regarding the center's current program. The consultant acting as a catalyst was mentioned most frequently six months later.

Table 5

Least Useful Aspects of Consultant's Visit

	Q2		Q3	
	N	% of 157	N	% of 89
Visit too short	5	3	13	15
Too little feedback, irrelevant	12	8	6	7
Not enough contact all levels of staff	4	2	7	8
Goals of visit not well developed	4	2	5	6
Not enough individual contact	5	3	2	2
No expertise or recommendations	-	-	5	6
General negative	4	2	1	1
Total (negative)	34	20%	39	45%

The comment most frequently mentioned as the "least useful aspect of the consultant's visit" was that the visit was too short. Actually this could be seen as a positive reaction in that centers apparently felt they would have benefitted from a longer visit. Some other comments relate to this same issue, specifically not enough individual contact and not enough contact among all levels of staff. Had the consultant visits been longer with more time available at the center, a number of these suggestions may not have been necessary.

The preceding tables report the types of comments staff made about the consultant's visit and how many times these comments were mentioned. Some of these comments are quoted in their entirety to provide a more accurate interpretation of the data in Tables 4 and 5. These quotes are grouped by questionnaire and include both positive and negative responses.

Post-Treatment (short-term) Questionnaire (Q2)
Positive Comments

> "Made us look objectively at how to change, how difficult it is to change, and how we need better channels to change."

"Confirmed our need for change. Assisted in focusing staff energies on common goal with some ideas of obtaining goal."

"Presence of consultants gave us opportunity to see our breakdown in mutual decision making -- carries over into areas of center decisions and division decisions."

"Most helpful in discussing methods for coordination and change -- helped articulate process.

"Most useful in serving as a catalyst for us to look at our decision-making process.

"Created a situation with travel money forcing group to analyze how they make decisions."

"Zeroing in on process of decision making in agency useful."

Negative Comments

"Visit too short -- no evaluation or suggestions of specific services."

"Felt topic of consultants was too broad and not well developed."

"Least useful was consultant's lack of knowledge, custom, local habits. Made some observations inappropriate for our center."

"Least useful was uncertainty of consultant's goals."

Post-Treatment (long-term) Questionnaire (Q3)

Positive Comments

"Most useful was the discussion relating to planned changes at the center. These ideas have remained with us till now, though more effort has to be made in the direction of consistency of such planning."

"Most useful in that it forced us to consider the dynamics of change."

"Most useful -- encouraging us to focus on and review our procedure for change."

"With a consultant present, there was a tendency to be honest in looking at ourselves and our programs."

"Most useful was non-threatening review of practices and procedures, plus sympathetic resource persons on specific questions and concerns."

> "Of great value is that a consultant's visit causes staff to get together and discuss problems and plans."
>
> "Most useful was follow-up evaluation report sent to us--gave us an objective picture of strengths and weaknesses."
>
> "Visit of consultants stimulated an administrative decision to spend more agency funds on staff visits to other agencies--and staff have made additional visits besides those funded by NIMH."

Negative Comments

> "Was not here long enough and not used effectively. Consultant should have been here for at least a week and made himself available to those staff who are interested in making changes."
>
> "Contact too short--staff did not have sufficient time to follow up ideas generated."
>
> "Lack of time for individual conference greatest handicap."
>
> "Least useful in that it became somewhat philosophic as opposed to problem solving."

Staff at each center were also asked for suggestions on how the visit could be improved. The following responses are quoted directly from the questionnaires:

> "A specific follow-up contact three-six months after first visit, dealing with major points discussed at site visit."
>
> "Consultant lends authority and impetus to staff's own--in our instance--fragmented thinking. In our particular situation, a planned re-visit by consultants would be helpful in wrapping up thinking stimulated by first visit."
>
> "If recommendations had been written up and copies given to all staff members during the visit--may have had great discussion."
>
> "Might have been more effective if objectives had been better stated and visit period was longer."
>
> "Set more specific agenda in advance."
>
> "Role of consultant should be clearer ahead of time; namely that consultant is more than observer, but can be a source of specific help."

Generally, staff at all levels would like more time with consultants, either a longer visit or a follow-up visit. Even though the consultants had reviewed common material regarding the project and the consultations and had attended the same orientation session, each one displayed a unique approach. Information on the techniques used by the consultant at a center came from the reactions of center staff and from the observations of the project staff member.

In all cases the consultant was accompanied by a project staff member who acted as an assistant. Assignment of consultant and project staff was made in such a way that, with one exception, each consultant was matched with at least two different project staff in different centers. For example, Consultant A might work with Staff Member A in one center, and with Staff Member B in another center. This allowed two independent observations of each consultant and diminished the possibility of generalizations on consultant techniques being based on the judgments of any one observer.

It was not within the scope of this project to conduct a thorough investigation of consultant activities, therefore no attempt was made to collect standardized data on consultations. However each consultant was observed on an informal basis and extensive notes were made. By combining these notes with the comments made by center staff regarding the consultants, some generalizations can be drawn. It should be clearly noted that these generalizations are based on informal observations of project staff and reactions of center staff.

Each consultant had his own style of consultation and responses from center staff indicated that the consultants' techniques as a change agent varied considerably. This variation occurred not only because each consultant used different techniques, but also because each center had its own concerns and needs.

Regardless of these variations, there were certain techniques used by a number of consultants in a number of settings that appeared to be more successful than other techniques. Some of these techniques are listed below.

1. The effective consultant listened. In some cases the great majority of the consultant's time was spent listening. When he spoke, it may well have been only to clarify a point, but his attention was focused on the concerns of the individual or center. The consultant's personal reactions, feelings or experiences were not allowed to take precedence.

2. The effective consultant did not step in or out of a role, rather he interacted with staff in all situations. Even during lunch, coffee breaks and car rides he conversed about some aspect of the center's plans, program or concerns. This meant that the consultant often was called upon to work in informal settings as well as the more structured individual interview or group meeting. While this demanded some adjustments in format, the most effective consultants did not change their techniques substantially regardless of setting.

3. The effective consultant was a storehouse of information. Gathering information from a host of sources seemed to be a personal characteristic of the consultant rather than a technique that can be taught. The consultant seemed able to ingest information from all senses, analyze and sift through it, and select that which was most pertinent. He might refer to sources typically not used by the sciences in gathering information--the lyrics of current hit songs, comments made during sporting events, etc. Inputs from any source were considered.

4. The effective consultant made use of past experience. This usually included references not only to how someone else had done something, but also to the problems they encountered and how they could have improved. He was willing to share his experiences--and not just his successes!

5. The effective consultant functioned as a pipeline. There were several cases of a consultant coming across something new at one center and at the next center repeating what he had just observed. The consultant rarely seemed to do this "on purpose." When asked about it later, the consultant was sometimes unaware that he had functioned as an "information conveyor."

6. The effective consultant suggested action alternatives. During feedback sessions or staff meetings, the effective consultant went beyond the theoretical or ideal situation and made specific recommendations.

7. The effective consultant saw the consultation as a personal learning experience and as an experience that would help his own center. Several consultants later mentioned they had filed away ideas for their own center or that they had seen something that a staff member would like to know about. It seemed as if the effective consultant later compared the visit with others he had conducted previously, perhaps noting differences and similarities.

8. The effective consultant suggested that centers work on problems they realistically could expect to solve. At times they dissuaded staff from approaching problems too large in scope and suggested starting with one section or redefining the problem to a manageable size.

9. The effective consultant acted as a catalyst. He capitalized on resources already existing and promoted common purpose and understanding. He stimulated discussion, moved staff to think in terms of the center's priorities, reached to find common agreement which may have been there all along but lay unrecognized.

A more complete account of the consultants' activities may be found in the 15 case studies, which provide data on the center, its activities and the consultants' intervention. These case studies can be found in Section II of this report.

VI. PROCEDURES AND RESULTS: SITE VISITS

Procedures

As discussed in Chapter II, personal contact is a critical variable in knowledge dissemination and utilization. Glaser & Coffey (1967, p. 65) state that:

> "Personal contact with the innovators may well be a crucial condition for the optimal dissemination of new ideas . . . . Probably the most impactful kind of personal contact is achieved when others personally can visit the demonstration site to learn by seeing the demonstration in the original setting, and then subsequently discussing implications and problems."

Staff visits to observe effective programs elsewhere thus were selected as the second interpersonal method of disseminating information among mental health centers.

Community mental health centers in two of the treatment groups--Consultant-Site Visit Group (Treatment Group A) and Site Visit Only Group (Treatment Group B) received stipends to visit centers with programs similar to those being considered at their own centers. Staff could visit other mental health centers, mental health agencies, or other institutions which were using practices of particular interest to their center. The travel stipend was for expenses related directly to the staff visits, up to a maximum of $500 per center.

The essential difference between the two groups making site visits was the intervention of outside consultants. Consultants visited Group A centers for a two-day period to act as "facilitators" or "change agents," to stimulate discussion of the change process; centers in Group B received no consultant assistance. Centers in both Treatment Group A and Treatment Group B received copies of the Source Book of Programs which provides information and new ideas about effective mental health programs. Both groups received Planning for Change, which discusses strategies for considering change.

A total of 38 centers (17 centers in Group A; 21 centers in Group B) were first notified by letter of the travel stipends. The final number of centers that made visits was 31 (15 centers in Group A; 16 centers in Group B). There had been no mention of the staff visits in previous contacts with the centers for two reasons: (1) announcing the availability of the travel stipend may have biased a center's decision on whether or not to participate, and (2) the final selection of centers to receive the stipend had not been made when earlier contacts with the centers had taken place.

Visits were scheduled to take place from January - May, 1973. This time period later was extended to July 31, 1973, since Group A centers would not make visits until after the consultants had visited the centers (February - April 1973).

Each center was responsible for making arrangements for their visits. However, to prevent some centers from being overburdened with visitors, all travel plans were checked by project staff in advance.

A problem of any dissemination strategy is the sharing of information with other staff members after gaining the new inputs. One requirement of the travel stipend was that staff members who made visits must describe the programs they observed to non-visiting staff. This requirement was designed to insure information dissemination to a wider group. Centers were also required to complete and return the post-treatment (short-term) questionnaire (Q2) and the site visitor report forms (QS). The site visitor report form was a form designed to provide an overview of the program visited and how information on the program was disseminated at the home center. Site visitors completed the form shortly after they returned from the visits. They described their reactions to the programs and centers they observed, as well as the response of staff at their home centers. A total of 113 staff made visits, however the total number of site visitor report forms is only 112 because one visitor did not complete the form.

Centers were encouraged to visit programs in the same or an adjacent NIMH region as their home center so that staff could visit more than one center with the $500 travel stipend. They were also encouraged to plan visits with two or more staff members participating so that: (1) reactions would be based on more than one observation, (2) more staff would be able to make visits, and (3) visitors could later support each other in introducing portions of programs they had observed. Also, by encouraging centers to visit other centers within their own area, additional or exchange visits might be an outcome of the first visit, since it would be financially and geographically possible.

Information on how the $500 travel stipends were used is based on two different questionnaires: the site visitor report form (QS) and the post-treatment (long-term) questionnaire (Q3). Copies of these questionnaires and other materials related to the site visits are in the Appendix section of this report.

The map (Figure 2) on the next page shows the locations of centers that made visits and the centers that received visits. Five centers received two visits: Rockland County Community Mental Health Center in New York, Tufts Community Mental Health Center in Massachusetts, Bernalillo County Mental Health Center in New Mexico, Prairie View Mental Health Center in Kansas, and Zumbro Valley Mental Health Center in Minnesota. Four centers that made site visits also received visits from other centers. Six (9 percent) of the 68 centers receiving visits were not located in the same or adjacent NIMH region as the centers that made visits.

A total of 113 staff members from 31 centers visited 68 mental health facilities. Following is a list of facilities visited, and the number of staff members that visited each facility.

Figure 2

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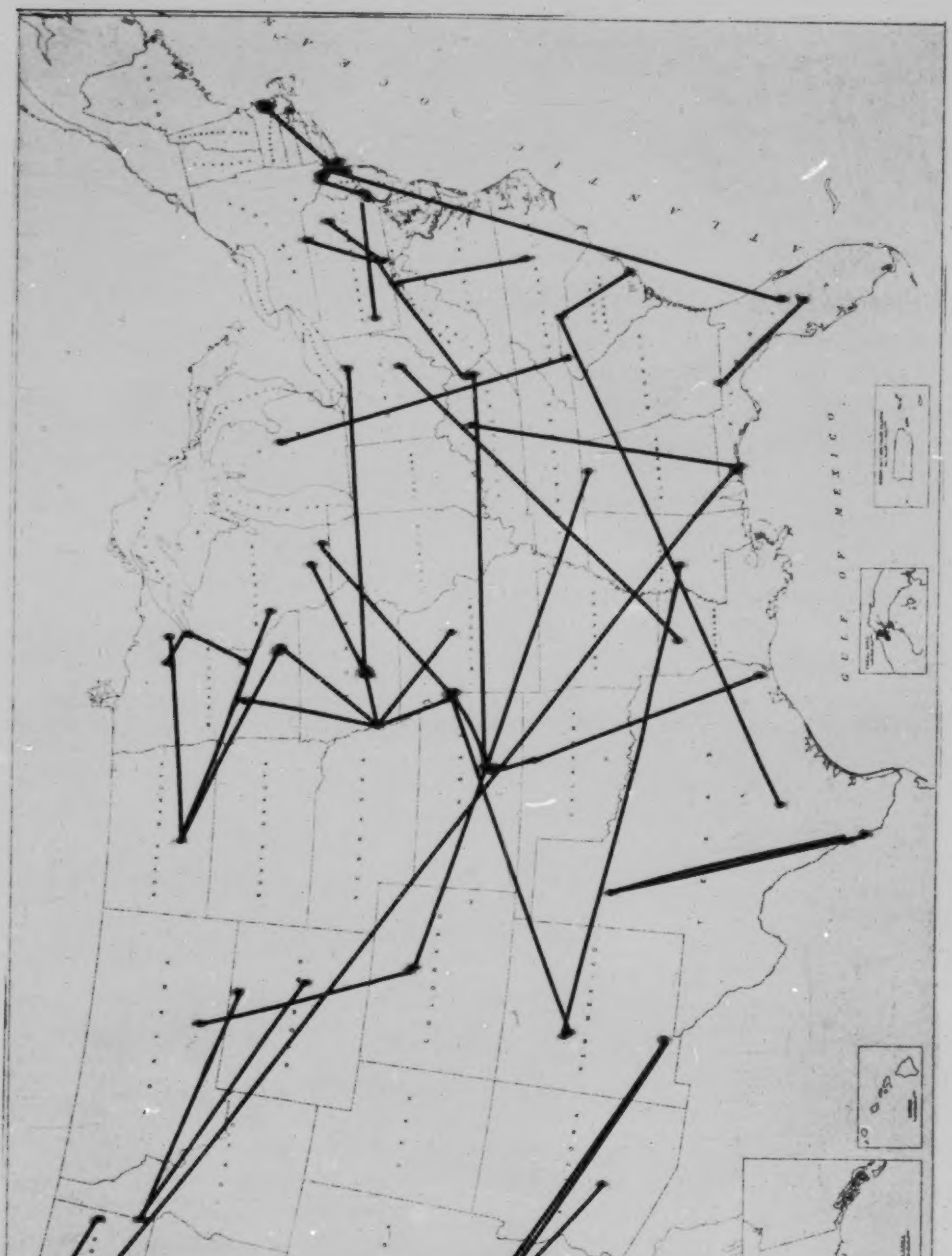
ATLANTIC OCEAN
GULF OF MEXICO
PACIFIC OCEAN

VISITS AMONG CENTERS

● Centers That Made Visits
● Centers Visited

Group A Center Visits

Facilities Visited	Number of Staff Visiting Facility
Good Samaritan Boys' Home Corona, California	3
David & Margaret Home LaVerne, California	3
Rosemary's Cottage Pasadena, California	2
Vista Del Mar Los Angeles, California	2
Devereaux School Santa Barbara, California	3
Wayland Community MH Center Phoenix, Arizona	1
Boys' Republic Chino, California	3
Huntsville-Madison Co. Community MH Center Huntsville, Alabama	1
East Side Community MH Center Bellevue, Washington	1
Seattle Community MH Center Seattle, Washington	1
Winter Haven Hospital Community MH Center Winter Haven, Florida	4
Central Wyoming Counseling Center Casper, Wyoming	2
Northeastern Wyoming MH Center Buffalo, Gillette, Sheridan, and Sundance, Wyoming	1

Facilities Visited	Number of Staff Visiting Facility
Lakeside Children's Home Madison, Wisconsin	2
Bellefaire Residential Treatment Center Cleveland, Ohio	9
Marshall I. Pickens Hospital Greenville, South Carolina	2
Northwoods Children's Home Grand Rapids, Minnesota (Inservice Training Program)	2
Alfred Adler Institute Wayzata, Minnesota	1
Orange Memorial Hospital Orlando, Florida	1
Mission District Neighborhood Health Center San Francisco, California	3
East Valley Community MH Center San Jose, California	3
South County MH Center San Martin, California	3
Rockland County Community MH Center Pomona, New York	8
North Richmond Community MH Center Staten Island, New York	2
Erich Lindemann MH Center Boston, Mass.	1
Tufts Community MH Center Boston, Mass.	1
Dorchester MH Center Boston, Mass.	1
Northwest San Antonio MH Center San Antonio, Texas	2

Facilities Visited	Number of Staff Visiting Facility
Charleston MH Center Charleston, So. Carolina	1
Ruston Regional MH Center Ruston, Louisiana	1
Robert Packer Hospital Community MH Center Sayre, Pennsylvania	3
Luzerne-Wyoming Community MH Center Wilkes-Barre, Pennsylvania	3
Mountain Comprehensive Care Center Prestonsburg, Kentucky	3
Totals: 33 Facilities	79 Visitors

Group B Center Visits

Facilities Visited	Number of Staff Visiting Facility
Bernalillo Co. Community MH Center Albuquerque, New Mexico	4
Community MH Center of Escambia County Pensacola, Florida	2
Prairie View Newton, Kansas	10
W. H. Trentman MH Center Raleigh, North Carolina	2
Jefferson County MH Center Arvada, Colorado	1
Polk Co. MH Center Des Moines, Iowa	3
Orchard Place Des Moines, Iowa	3

Facilities Visited	Number of Staff Visiting Facility
West Central MH Center Willmar, Minnesota	4
Mid-Missouri MH Center Columbia, Missouri	2
Zumbro Valley MH Center Rochester, Minnesota	2
Wyandotte Co. Community MH Center Kansas City, Kansas	2
Clayton MH Center Riverdale, Georgia	2
Range MH Center Virginia, Minnesota	1
Mississippi River MH Center Independence, Wisconsin	1
Fort Logan MH Center Denver, Colorado	1
Angie Hall Hospital for Children with Learning Disabilities Beaumont, Texas	5
Rio Grande Center Laredo & Zapata, Texas	2
Irene Stacy Community MH Center Butler, Pennsylvania	1
Sound View-Throgs Neck Community MH Center Bronx, New York	1
Nanaimo General Hospital Nanaimo, British Columbia	2
Benton-Franklin MH Clinic Richland, Washington	1

Facilities Visited	Number of Staff Visiting Facility
Spokane MH Center Spokane, Washington	2
Clark Co. MH Center Vancouver, Washington	3
Westside Community MH Center San Francisco, California	1
Northeast Community Care Center San Francisco, California	1
Effectiveness Training Associates Wichita, Kansas	1
West-Ros Park MH Center Hyde Park, Mass.	6
Harry Solomon MH Center (Share, Inc.) Lowell, Mass.	6
Tufts Community MH Center Boston, Mass.	6
Boston State Hospital Boston, Mass.	6
Massachusetts MH Center Boston, Mass.	6
Totals: 31 Facilities	90 Visitors
Grand Total: 64 Facilities	169 Visitors

Results

Each center was responsible for selecting the sites and programs they wanted to visit. Group A had the opportunity of asking the consultant for suggestions of specific programs to visit. Both groups had copies of the Source Book of Programs prior to their visits. Reasons that sites were selected for visits are reported in Table 6. This question was asked on the post-treatment (long-term) questionnaire (Q3) and answered only by staff who made site visits.

Table 6

Reason Site Was Selected For Visit

	Treatment Group A		Treatment Group B		Total	
	N	%	N	%	N	%
To observe specific aspects of program at center	7	18	18	43	25	30
Center similar to ours	12	30	3	7	15	18
Reputable, interesting program	10	25	4	9	14	17
Similar program being considered at our center	2	5	6	14	8	10
Location of center, proximity	3	7	5	12	8	10
Recommended by someone outside center	3	7	2	5	5	6
Selected for me to visit	1	3	3	7	4	5
General learning experience	2	5	-	-	2	2
Read about it in Source Book	-	-	1	2	1	1
Total responding	40*	100%	42*	99%	82	99%
No response & non-visitors	35		15			
Total (overall)	75		57			

*Number of staff visitors who responded to question.

The three most frequent reasons sites were selected for visits were (1) to observe specific aspects of a program at a center, (2) the centers were similar (region, population served, area, size) or (3) the center had a reputable, interesting program.

A question asked on the post-treatment (long-term) questionnaire (Q3) related to the selection of programs for site visits. Table 7 reports how staff first learned about the programs visited. This question was answered only by staff who made visits.

Table 7

Source of Information About Program at Site Visited

	Treatment Group A		Treatment Group B		Total	
	N	%	N	%	N	%
Source Book of Programs	15	34	18	42	33	38
Director or other staff member at center made suggestion	11	25	13	30	24	28
Someone outside center made suggestion	10	23	7	16	17	19
Other	8	18	3	7	11	13
Read about it somewhere	-	-	2	5	2	2
Total responding	44*	100%	43*	100%	87	100%
No response & non-visitors	31		14			
Total (overall)	75		57			

*Number of staff visitors who responded to question.

The Source Book of Programs was mentioned most frequently (37 percent of the time) as the first source of information in learning about programs visited. Although this was an expected outcome since the book had been supplied for this use, it does give some indication of the potential use of the Source Book as a source of new program ideas. Because it has a geographical index, the Source Book also allows staff to learn about nearby programs.

The number of staff from a given center making site visits varied considerably. Some centers sent from one to six visitors to one center, other centers sent as many as 14 visitors to two centers. Table 8 reports the procedures used to select staff to make site visits. This question was asked of all respondents on the post-treatment (long-term) questionnaire (Q3).

One objective of the staff visits was to provide an opportunity for staff at different levels to make visits. Discussions and meetings were used to select visitors in 38 percent of the cases, indicating the use of group-decision-making procedures. It is not known exactly how many levels of staff actually made visits, however six centers sent more than five staff members and 22 centers sent more than one staff member on visits.

Table 8

Procedures Used in Selecting Staff to Make Site Visits to Other Centers

	Treatment Group A		Treatment Group B		Total	
	N	%	N	%	N	%
Administrative staff made selection	11	15	21	37	32	25
Director made selection	19	26	12	21	31	24
Staff meeting	20	27	10	18	30	23
Informal discussion with director and staff	13	18	7	12	20	15
Other	5	7	4	7	9	7
Written requests from staff to decision maker	5	7	3	5	8	6
Total responding	73	100%	57	100%	130	100%
No response	2		-			
Total	75		57			

A variety of programs were observed by staff members. During some visits, staff observed only one program at a center; other staff members observed more than one program, and some staff observed the total program at a center. A total of 208 programs were reported by the 113 staff members who made visits. Table 9 reports the type of programs observed.

Table 9

Programs Visited With Travel Stipend

	Treatment Group A		Treatment Group B		Total	
	N	%	N	%	N	%
Special treatment programs	30	28	36	35	66	32
Outpatient programs	15	14	12	12	27	13
Inpatient programs	13	12	12	12	25	12
Other	10	9	15	15	25	12
Consultation & education	14	13	8	8	22	11
Organization & administration	11	10	5	5	16	8

Table 9 (Continued)

	Treatment Group A		Treatment Group B		Total	
	N	%	N	%	N	%
Rehabilitation	4	4	6	6	10	5
Staff development	3	3	3	3	6	3
Crisis programs	4	4	-	-	4	2
Program evaluation	1	1	2	2	3	1
Promotion & financial support	2	2	1	1	3	1
Program planning	0	-	1	1	1	-
Total	107	100%	101	100%	208	100%

The most frequently observed program is "Special treatment programs." Within this category special services for children and adolescents was mentioned 44 times or 67 percent of the time. In Category "Other," observing the total program of center was mentioned most frequently--19 times or 76 percent of the time.

Short Term Results of Visits (QS)

Site visitors observed a total of 208 programs at the 68 centers visited. Of the 112 visitors who responded to QS, almost all (97 percent) reported they had observed aspects of programs that would be useful at their centers, and nearly as many (89 percent) reported they had observed aspects that would not be useful at their centers. Site visitors were asked to make recommendations to their home center about the programs they had observed. Table 10 reports the responses.

Table 10

Site Visitors' Recommendations About Programs Observed

	N	%
Start identical program	6	5
Start program using some components of observed program	69	62
Use some components in existing program	16	14
Don't start program	13	12
No response	8	7
Total	112	100%

Eighty-one percent of the 112 respondents recommended using some or all of the components of the programs they had observed.

One requirement of the travel stipend was that site visitors make presentations to other staff members when they returned from their site visits. The purpose of this requirement was to insure dissemination of the information about the programs visited. Table 11 reports the procedures centers used in meeting this requirement.

Table 11

Type of Meetings Held When Site Visitors Returned From Visits

	N	%
Regular staff meeting	71	63
Special meeting	25	22
Other	8	7
No response	8	7
Total	112	99%

Three questions on QS asked the site visitors to report how the staff reacted to their presentations on the programs they had observed. In general, staff reactions to the programs presented during these meetings were positive. Seventy-three percent of the site visitors indicated the staff had a favorable reaction to the programs; 72 percent indicated the programs were directly useful or useful with modifications at their own centers; and 65 percent of the site visitors indicated the staff expressed interest in implementing programs similar to those visited at their own centers.

One question asked the site visitors to report their reactions to the visits and the programs they had observed. Table 12 summarizes these comments.

Table 12

Site Visitors' Reactions to Visits to Other Centers

	N	Percent N=200
Opportunity to share new ideas, information	28	14
Specific aspects of program positive	26	13

Table 12 (Continued)

	N	Percent N=200
Opportunity to compare programs; provided reassurances about own program	23	11
Good learning experience discussion	15	8
Staff cohesion at center visited	14	7
Provided new and different perspective	12	6
Flexible, well-run organization	10	5
Renewed enthusiasm for job	7	4
Positive reaction; too different to compare program to own center	4	2
General positive	54	27
Non-committal; program too different--unable to compare	3	2
Non-committal, no judgment	2	1
Negative comments re visit	2	1
Total	200	101%

Thirty-two site visitors did not respond to the question. Of the 200 comments received from the 80 site visitors, 97 percent were positive and 3 percent were negative. When no responses are included in the percentages (N=232), 82 percent of the comments were positive, and 3 percent were negative and 14 percent did not respond.

In order to provide a clearer picture of the type of reactions staff had to the visits, some responses are reported from the site visit report form. The responses are arranged by treatment group.

Group A

> "Feel personal contact is best way of transmitting information. Trip reinforced need to periodically make such contacts. . . . to discuss programs and techniques. Very rewarding . . . . would like to make more trips if not so costly."

> "The best aspect of this program was the communication among those attending (all over state) regarding the discussion of philosophies, operating methods, idea and experience exchange."

"Visit motivated me to look within own staff for new resources, to look to community in which we operate and set new goals for our program. Gave me renewed enthuiasm for my job."

"Enlightening, a fresh perspective to interagency problems and new ideas of how to cope with them."

"Their staff presented us with a great deal of information and suggestions. We would like to invite some of them as consultants to our staff."

"Visit provided opportunity to put our program in perspective. An excellent idea."

"Visit gave me renewed courage to fight for programs (at our center)."

Group B

"Visit valuable in terms of sharing other centers' information and for utilization of some programs."

"Better learning experience than special seminar or college course. Visit very good for perspective development."

"Very helpful in terms of making our own program more comprehensive. Gained ideas. Will be receiving written material we may implement."

"Very much worthwhile, not only in terms of positive learning but in terms of understanding our directions better."

"Visits rejuvenating--stimulated ideas, renewed determination to follow through on various projects despite discouraging results of past. Chance to share ideas, provide an outside check on how well we are doing our job."

"Learned new things and confirmed some beliefs by seeing them in practice. Our staff seems closer in thinking and practices than before visit, more harmonious."

"Visit very worthwhile. Picked up number of ideas which can be used in public school setting."

"Very educational and enjoyable. Felt well received and learning great deal . . . . Stimulated to think beyond our present program."

Six staff members from an urban center reported their reactions to the visits with a detailed written report. The following two paragraphs are quoted from this report:

> "One of the most rewarding aspects of this visit was meeting a staff of such high caliber. What impressed us so greatly was their dynamism and willingness to experiment. Their backgrounds comprise an interesting mixture of highly trained experts and non-skilled lay people whose overall approach to one another and their work seemed unpretentious, dedicated, and quite realistic. This meeting was a high point."

> "As a group we felt that this visit helped us to understand and appreciate our center and we feel that if possible other staff members should be given an opportunity to see other centers' programs. Often we lose perspective on community mental health because we tend to assume that our way is 'the way.' Seeing other programs helps us to gain perspective and helpd us to view our programs in a new light. We felt that the Source Book, though describing various programs,did not permit us to gain this perspective."

In general, the site visitors, reactions to their visits were extremely positive and enthusiastic. There was no difference in the reactions between the two treatment groups.

Long Term Results of Site Visits

In order to measure the effects of staff visits to other centers over a longer period of time, questions were asked on the post-treatment long-term questionnaire (Q3).

Two questions asked of all respondents (visitors and non-visitors) were designed to measure the direct effects of staff visits, i.e., was the site visit useful in considering new practices and were any of the observed practices implemented. Tables 13 and 14 report the responses to these questions by treatment groups and total.

Table 13

Extent to Which Site Visit to Other Centers Has Been Useful in Considering New Practices at Your Center

	Treatment Group A		Treatment Group B		Total	
	N	%	N	%	N	%
Extremely useful	6	8	1	2	7	5
Very useful	13	17	19	33	32	24
Moderately useful	27	36	21	37	48	36

Table 13 (Continued)

	Treatment Group A		Treatment Group B		Total	
	N	%	N	%	N	%
Slightly useful	18	24	13	23	31	23
Not at all useful	6	8	1	2	7	5
No response	5	7	2	4	7	5
Total	75	100%	57	101%	132	98%

Sixty-five percent of the respondents reported the site visits were useful, very useful, or extremely useful in considering new practices at their centers.

Table 14

Center Implementation of Practices Observed
During Site Visit

	Treatment Group A		Treatment Group B		Total	
	N	%	N	%	N	%
Yes	28	37	26	46	54	41
No	34	45	23	40	57	43
Don't know	10	13	4	7	14	11
No response	3	4	4	7	7	5
Total	75	99%	57	100%	132	100%

Information on exactly which programs were implemented at the centers as a result of staff visits is not available. However, the high number of respondents reporting that practices observed were implemented is an indication that the information on the observed programs was disseminated widely among the staff at centers. The high "Yes" response also indicates the practices observed at other centers were compatible with the needs of the centers receiving the travel stipends. Table 15 reports the extent to which innovations observed were compatible with the needs of the centers receiving travel stipends.

Sixty-six percent of the respondents reported the innovations observed were compatible with the needs of ther centers. Only six respondents (less than 5 percent) reported the innovations were not at all compatible.

Table 15

Extent to Which Innovations Observed at Other Centers Were Compatible With the Needs of Your Center

	Treatment Group A		Treatment Group B		Total	
	N	%	N	%	N	%
Extremely compatible	5	7	-	-	5	4
Very compatible	16	21	16	28	32	24
Moderately compatible	24	32	26	46	50	38
Slightly compatible	15	20	12	21	27	20
Not at all compatible	6	8	-	-	6	5
No response	9	12	3	5	12	9
Total	75	100%	57	100%	132	100%

Almost all the information and comments received on the site visits has been positive. The negative comments resulted from visitors' reactions to certain aspects of programs they had observed and the feeling that the sites visited had been too different from their own centers.

Overall, both the short and long-term results of the site visits indicate there was a wide dissemination of the information received during visits among staff at the centers that made visits, that this new information was used in considering new practices at these centers, and that many centers implemented practices they observed during the visits. However, the reactions of one group of staff members from Group B who made visits describe the concerns they had upon returning to their center and may provide some insight into the problems encountered by other staff who made visits.

> "On our return and as we reviewed our experience, we felt that we had seen several programs, such as the Adolescent School or the Geriatrics Program, that uses existing community facilities that could be applied to some degree here. However, we did not know how to use these ideas or how they might be implemented. This raised the more general question as to how new ideas are generated and implemented. Related questions are those such as: Who here seeks out new ideas and programs? If staffing has a new idea which he feels is good where does he go with it? What is the staff's role in planning and implementing new programs and ideas? We feel that one useful outcome of our visit might be an exploration of this problem."

VII. PROCEDURES AND RESULTS: WRITTEN MATERIALS

Procedures

The second primary method of information dissemination to be studied was written dissemination. Previous research (Roberts & Larsen, 1971) indicates that although staff prefer interpersonal communication as a means of first learning about a new idea, they also refer to written material, especially when doing background research or when needing specific detailed information. Research also indicates that a certain type of written material is more likely to be used--that which is understandable, brief, and easy to comprehend.

For the purposes of this project, written materials were prepared to match these criteria and to promote information exchange among community mental health centers. These materials were the *Source Book of Programs: Community Mental Health Centers* and *Planning for Change*. The two were designed as companion volumes, though each could be used independently.

The *Source Book of Programs* was designed to serve as a directory of ideas for community mental health centers. It presented information about programs found to be effective by the centers which developed and used them. No attempt was made to conduct independent evaluations of programs before including them in the book. The data for making such judgments were not available to project staff; further, to verify which programs were, in fact, exemplary would have required extensive interviews and site visits. Such an evaluation was beyond the scope of this project. Therefore the *Source Book of Programs* relied on the evaluation of individual centers.

In general, all programs submitted were included in the *Source Book*. There were a few exceptions where insufficient information was reported, limiting the writers' ability to prepare an adequate description. The titles and brief descriptions of these programs are found at the end of each section.

At one point the suggestion was made that only those programs which appeared to be novel or innovative be included. This approach was not followed, however, since what is familiar to one center may be new to another, especially when dealing with a national audience. Of course the most innovative centers may find many of the descriptions "old hat." Yet even (or especially) with innovative centers, it would be most unusual if staff were uninterested in programs at other centers and did not see the potential for transferring or adapting portions of programs for their own use.

Planning for Change was designed as a companion to the *Source Book of Programs*. While the *Source Book* provides information on programs, *Planning for*

Change suggests methods for implementing this information. The booklet, based on the A VICTORY model of Dr. Howard Davis, was designed to be easy to read and understand. *Planning for Change* is not a complete or exhaustive treatment of the A VICTORY change model, rather it focuses on the model's high points from a "how-to-do-it" perspective. The *Source Book of Programs* and *Planning for Change* were sent to centers in Treatment Groups A, B, and C. The interest of this chapter focuses primarily on Treatment Group C, since these materials were the only dissemination component furnished to this treatment group.

The procedure for developing the *Source Book* was designed to complement other project activities. As explained in Chapter IV, the initial contact with each center consisted of a letter and questionnaire sent to the center director. One of the questions on that form asked for a list of effective practices the center had introduced during the past two years, and the name of a person to contact for more information. Several months later those persons listed by the director were asked to supply additional information on their programs for use in the *Source Book*. (A sample of the data collection form is found as Appendix F.) Information was requested from approximately 600 persons; approximately 350 responded with adequate data.

Project staff then prepared this material in a form that would be as complete as possible and yet brief enough to be of use at a center. Several alternative formats were planned and tried out, with the following eventually adopted.

Outline of Format for Effective Practice

Title	The title is brief and reflects the main components of the innovation.
Summary	A sentence or two briefly describes the project.
Background	Information on the center, characteristics of the community, why the practice was initiated, and other relevant information.
Description	
a. Purposes	The goal of the practice and the need it fills.
b. Personnel	A description of the personnel involved, the skills they required, additional training they received and the proportion of time each was involved.
c. Procedures	A description of organizational details and actual procedures.
d. Costs	Both initial and operating costs as well as funding sources.

Outcomes and Evaluation	Evidence of success as reported by center.
Other Relevant Information	Any special conditions.
Further Information	Name, address and phone number of person able to supply additional information.

A description of each program was prepared using the above format and included in the Source Book of Programs. The descriptions were arranged in four main sections with the following subcategories:

- I. Entry and Treatment Programs
  - A. Intake Procedures
  - B. Emergency Services
  - C. Inpatient Programs
  - D. Day Treatment
  - E. Aftercare and Rehabilitation
  - F. Other Treatment Programs

- II. Special Patients Served
  - A. Children
  - B. Youth
  - C. Family and Parents
  - D. Drug Abuse
  - E. Alcoholism
  - F. Mentally Retarded
  - G. Elderly

- III. Community Services
  - A. Community Programs
  - B. Satellite Centers and Outreach
  - C. Citizens Involvement
  - D. Consultation to Schools
  - E. Consultation to Legal Systems
  - F. General Consultation

- IV. Management and Administration
  - A. Planning
  - B. Evaluation
  - C. Data Systems
  - D. Organization
  - E. Procedures
  - F. Training

Results

Staff from centers in all treatment groups were asked about their use of the written materials. The following table reports respondents' ratings of the book's usefulness immediately following its receipt and again six months later.

Table 16

Extent Source Book Useful

	Q2						Q3					
	Treatment Groups						Treatment Groups					
	A		B		C		A		B		C	
	N	%	N	%	N	%	N	%	N	%	N	%
Extremely useful	12	12	7	10	-	-	1	1	0	0	1	2
Very useful	29	28	14	20	9	21	10	13	6	11	2	4
Moderately useful	28	27	16	23	15	35	13	17	15	26	12	24
Slightly useful	12	12	7	10	8	19	24	32	15	26	11	22
Not at all useful	1	1	-	-	-	-	13	17	7	12	5	10
Did not see	11	11	22	32	11	25	-	-	-	-	-	-
No response	9	9	3	4	-	-	14	19	14	25	18	37
Total	102	100%	69	99%	43	100%	75	99%	57	100%	49	99%

When percentages are computed based on a combination of Q2 and Q3 and using only the responses of persons who made a judgment on the book's usefulness, the following figures resulted.

Table 17

Extent Source Book Useful

(Combination of Q2 and Q3 and Deleting
"Did not see" and "No response")

	Treatment Group A		Treatment Group B		Treatment Group C		Total	
	N	%	N	%	N	%	N	%
Extremely useful	13	9	7	8	1	2	21	7
Very useful	39	27	20	23	11	17	70	24
Moderately useful	41	29	31	36	27	43	99	34
Slightly useful	36	25	22	25	19	30	77	26
Not at all useful	14	10	7	8	5	8	26	9
Total	143	100%	87	100%	63	100%	293	100%

The data indicate that the Source Book was used to some degree by 91 percent of the respondents. When asked how the book was used, the following data resulted.

Table 18

How Source Book Was Used

(Q3 only)

	Treatment Group A		Treatment Group B		Treatment Group C		Total	
	N	%	N	%	N	%	N	%
Read more than 10 descriptions	37	49	34	60	12	25	83	46
Read fewer than 10 descriptions	16	21	6	11	11	22	33	18
Glanced briefly	8	11	2	4	12	24	22	12
Had never seen	12	16	15	26	12	24	39	22
No response	2	3	-	-	2	4	4	2
Total	75	100%	57	101%	49	99%	181	100%

If the non-respondents and those who had not seen the book are deleted, the following figures emerge.

Table 19

How Source Book Was Used

(Deleting "Had never seen" and "No response")

	Treatment Group A		Treatment Group B		Treatment Group C		Total	
	N	%	N	%	N	%	N	%
Read more than 10 descriptions	37	61	34	81	12	34	83	60
Read fewer than 10 descriptions	16	26	6	14	11	31	33	24
Glanced briefly	8	13	2	5	12	34	22	16
Total	61	100%	42	100%	35	99%	138	100%

These data indicate that generally people who used the Source Book used it in a rather thorough manner. Only 16 percent indicated they gave the book a cursory glance while 84 percent read at least one description. It is interesting to note the impact of interpersonal communication combined with written; in Treatment Groups A,and B, 90 percent of the respondents read at least one description whereas Treatment Group C, which received no interpersonal component, reported that only 65 percent read at least one description.

The objective of the Source Book of Programs was that it serve as a source of ideas and could be used as a reference; it was never conceived to be a comprehensive listing of programs. In order to determine whether the Source Book had met this objective, staff were asked whether the Source Book had provided new ideas for the center. The results can be found in the following table.

Table 20

Source Book Providing New Ideas

(Q3)

	Treatment Group A		Treatment Group B		Treatment Group C		Total	
	N	%	N	%	N	%	N	%
Yes	31	41	26	46	14	29	71	39
I don't know	20	27	13	23	8	16	41	23
No	19	25	14	25	11	22	44	24
No response	5	7	4	7	16	33	25	14
Total	75	100%	57	101%	49	100%	181	100%

Combining all groups, 39 percent responded that the Source Book had provided new ideas. Again, the groups with a combination of interpersonal and written techniques reported that they had found more new ideas in the written materials (41 and 46 percent) than the group receiving only written materials (29 percent).

Staff were invited to supply feedback indicating aspects of the Source Book which they felt to be most and least useful.

Table 21

Most Useful Aspects of Source Book

	N	%
Source of new ideas	45	16
Specific sections	41	15
Organization of material, index helpful	37	13

Table 21 (Continued)

	N	%
Useful for planning and contacts	35	13
Concise descriptions, good format, practical	34	12
Increased awareness of programs elsewhere	21	8
Comprehensive	16	6
Basis for comparison of programs	14	5
Useful to keep up-to-date	12	4
General	22	8
Total	277	100%

Least Useful Aspects of Source Book

	N	%
Too short	27	24
Descriptions not detailed enough	26	23
Specific sections weak	14	13
Evaluations not thorough	14	13
Descriptions no longer accurate	7	6
Too long	7	6
General	16	14
Total	111	99%

Feedback seems to indicate staff would like a more comprehensive book, even though the Source Book contained descriptions of over 350 programs. Some respondents also indicate that the descriptions should be presented in greater detail (N=26) although others felt the concise descriptions were beneficial (N=34). Several comments were received describing rather novel uses for the book. Three individuals said they used the book as a source of referral for clients who were moving. The following are statements from center staff describing individual reactions to the Source Book.

> "Thank you for the Source Book. I'm really impressed. I hope you will solicit a second round of Source Book contributions. The staff here will be much more motivated to write up their projects in this format once they have seen the Source Book and I suspect the effort would be similar in other places.

> "I found (this document) to be an excellent resource of creative approaches to the solution of mental health/mental retardation problems."

> "I recently had the opportunity to review the publications Source Book of Programs and Planning for Change which your office sent to our center. I found these to be most informative and feel they would be of direct value to our district planning project."

> "I have just seen your impressive Source Book of Programs: Community Mental Health Centers. Would it be possible for us to have two copies to be used in teaching? We have a program for training mental health center leaders and your Source Book would be a valuable resource."

> "I was delighted and impressed when a colleague of mine showed me a copy of the AIR Source Book of CMHC programs. I thought it to be a valuable and needed resource."

> "We feel the information in the Source Book of Programs: Community Mental Health Centers can be most useful to our Regional Office staff in working with the community mental health centers in our region."

Feedback was also requested on the booklet Planning for Change. This 40 page booklet was included in a packet on the inside front cover of the Source Book of Programs. For some reason, the responses from people who had never seen the booklet were high. When coupled with no response, the figures indicated that 167 persons or 42 percent of the total were unfamiliar with the booklet. This may have been due to the rather inconspicuous location of the booklet, or the booklet may have been removed and the Source Book passed on without the booklet. At any rate, the resultant figures leave too few respondents for the results to be interpreted by treatment group with reasonable validity. Therefore all results to questions involving Planning for Change are presented as totals across treatment groups and based only on respondents indicating familiarity with the booklet (N=228).

When asked how useful Planning for Change was to local staff, the following responses were reported:

Table 22

How Useful is Booklet Planning for Change

	N	%
Extremely useful	7	3
Very useful	27	12
Moderately useful	63	28
Slightly useful	82	36
Not at all useful	49	21
Total	228	100%

Even though 79 percent of respondents indicated that the booklet was of some use to them, the overall positive response was lower than responses to other components of the project. A possible reason for this may be detected in data reporting how the booklet was used.

Table 23

How Used Planning for Change

	N	%
Read and discussed booklet with colleagues	20	20
Read but no discussion with colleagues	43	42
Glanced briefly	39	38
Total	102	100%

Only 20 percent of the respondents reported that they discussed the concepts presented regarding the change process with others at their center. Of these 20 persons, 12 of them were in the group receiving a consultant visit and they may have been referring to the discussions the consultants led on Planning for Change and change in general. In most organizations where organized change occurs, there must be some communication about plans, problems, etc. It is not too surprising that the booklet would be not at all useful or slightly useful when presented in the context of no discussion with other staff.

As with the Source Book, feedback on Planning for Change was invited from center staff. Following are the most useful and least useful aspects of the booklet.

Table 24

Most Useful Aspects of Planning for Change

	N	%
Useful model or system	19	19
Well stated and organized	16	16
Practical	15	15
Tells how to implement	8	8
Highlights major steps in process	8	8
Specific features	6	6
General comments	28	28
Total	100	100%

Table 24 (Continued)

Least Useful Aspects of Planning for Change

	N	%
Too simplistic	16	22
Not relevant to immediate situation	15	20
Nothing new	10	14
Poor format	9	12
Too brief	7	10
Too abstract	6	8
General comments	10	14
Total	73	100

When most and least useful comments are compared, they tend to nullify each other. For example, 16 persons said the model was too simplistic while 19 said it was useful; 16 responded that the material was well stated and organized whereas 9 felt the format was poor; 15 persons felt the model was practical and 6 judged it too abstract.

Perhaps some representative comments from questionnaires will explain the reactions of staff.

> "I found the booklet was written in a very practical and concise manner. I didn't have to wade through tons of words to get to the meat. I've already put it to work in setting my own objectives and plans for the next quarter."
>
> "Very useful--the systematic approach to change. Specifically: Analysis of background situation, emphasis on involving community, handling staff resistance, providing staff rewards for cooperation. Too often these considerations are omitted in the rush to change."
>
> "Although brief in content, it highlights essential steps that should be taken in bringing about changes--whether small or large."
>
> "It is quite specific and we make better use of it as we look into long-range planning for development of agency services."
>
> "Dedicated to idea that change occurs because of intellectual factors (i.e., not based on rationale). What we need to change is influence of non-intellectual factors, not accommodate ourselves to them."

> "I feel the ideas and suggestions are good, but doesn't give much detail on the 'how's.' My suggestions would be to make the book larger or add a bibliography."
>
> "Just to send booklets isn't enough . . . . Change is harder to accomplish than to send some documents telling people how to go about it."

The final comment nicely summarizes the impact of the written materials on Treatment Group C. Although receiving the same materials as Groups A and B, Group C made less use of the materials. Staff in Group A, which had experienced the consultants' visits, were more likely to discuss the written materials and to share ideas among themselves. Those in Groups B and C showed a greater tendency to use materials on an individual basis.

VIII. COMPARISON OF DIFFUSION TECHNIQUES

The diffusion techniques investigated in this project fell into two main groups--interpersonal and written. The interpersonal techniques involved consultant assistance and site vist; the written techniques involved a comprehensive Source Book of Programs and a small manual, Planning for Change.

The primary criterion used to evaluate the effectiveness of these techniques was the number of innovations considered at a center. An investigation of the number of innovations considered could include innovations actually implemented, as well as innovations planned but not yet implemented.

This criterion, number of innovations considered, is not as straightforward as it may first appear. While renewal and modification are signs of a healthy organization, change in the extreme may lead to instability, lack of program maturity, and confusion. A center reporting an unusually high number of innovations may actually reflect circumstances which may or may not be positive. Furthermore, some centers are more or less in need of change and improvement than other centers. For example, new centers are likely to report more changes because they are starting new programs. Even with these limitations, however, consideration of innovations is the goal of any diffusion technique and thus the main criterion for this project.

The number of innovations reported by centers in the treatment and control groups ranged from 0 to 30 over a time period of two years. On the basis of innovations reported, centers were divided into three categories: few (4 or less), some (5-8) and many (9 or more).

A chi-square test was used to determine whether there was an association between treatment groups and number of innovations reported. When using pre-treatment data no differences were found among the groups in the number of innovations ($X^2 = 6.86$, df = 6 - Appendix 28). While post-treatment data did not reflect differences either ($X^2 = 9.99$, df = 6 - Appendix 29) an inspection of the table did show some shifts of the group receiving staff site visits towards increased consideration of innovations.

The mean values for pre-treatment and post-treatment data are as follows:

Table 25

Mean Number of Innovations Considered

	Pre-treatment	Post-treatment
Treatment Group A	7.13	7.40
Treatment Group B	7.29	9.71
Treatment Group C	7.40	6.67
Control Group (Group D)	6.07	6.93

t-tests were applied to test for differences between means, however no significant differences were obtained (Treatment Group A, t = .16, df = 28, n.s.; Treatment Group B, t = -1.64, df = 26, n.s.; Treatemnt Group C, t = .47, df = 28, n.s.; Control Group, t = -.63, df = 28, n.s.). The groups receiving interpersonal diffusion techniques, A and B, were combined as were the groups receiving no interpersonal communication, C and D. t-tests were applied to these combined groups, however no significant differences were found on either pre-treatment or post-treatment data (pre-treatment, t = .42, df = 57, n.s.; post-treatment, t = 1.59, df = 57, n.s.).

The combined interpersonal groups (A & B) and written groups were also analyzed using a chi-square test. No differences were found between groups in number of innovations reported in pre-treatment data (X^2 = .23, df = 2 - Appendix 38) or in post-treatment data X^2 = 3.55, df = 2 - Appendix 39).

While none of the data approach the level needed for significance at the .01 or .05 level, all data indicate a trend in favor of interpersonal diffusion methods. Results of both chi-square and t-tests suggest that combined group A & B was slightly more likely to consider innovations than combined group C & D.

Chi-square tests were also used to determine association between center characteristics and number of innovations reported. The analysis was based on data from the pre-treatment questionnaire and later on data from post-treatment questionnaires. No differences were found at either time relating to geographic region, center ownership, or size of center (Appendices 30-37).

In the case of age of center, a relationship was found based on pre-treatment data between age of center and number of innovations. Evidently younger and older centers are more likely to implement new programs while those in the middle report fewer innovations. For young centers, every program is new, hence many innovations; centers in the middle group may be establishing programs first initiated a few years earlier; older centers may be responding to a need to revitalize their program, thus again reporting many innovations. When the analysis was again conducted, based on post-treatment data, these differences were not found. This may reflect a reduced level of federal support occurring during the years covered by the project and the resultant decrease in initiation of new programs.

With the possible exception of age of center, these data indicate that the likelihood of innovation depends on variables other than these center characteristics.

The mean number of innovations (pre-treatment) reported for each of these center characteristics can be found in Table 26. Post-treatment mean scores are reported as well in Table 27. The treatment intervention may also have been too limited and of too short duration.

The fact that no significant relationships were found between the independent variables and the number of innovations reported does not necessarily mean that no such relationships exist. Judgments of observers and participants alike indicate that certain intervention techniques were more helpful than others and that results did in fact occur. The lack of statistical proof may result from a number of conditions. As noted earlier, the criterion, number of innovations considered, has some limitations which may have been instrumental in failing to detect statistically significant differences. In addition the measurement instruments may have been unable to detect subtle differences, and there were problems involved in imposing a rigid experimental design on service-oriented activities.

Since this condition was anticipated early in the project, staff were asked both in pre-treatment and post-treatment questionnaires to provide their judgment on which diffusion techniques they felt were most helpful for learning about mental health practices. The responses are found in Table 28.

Table 26

Mean Number of Innovations Reported (Pre-treatment)

	Treatment Groups			
	A	B	C	D (Control)
Size of Center				
Small	5.43	6.33	8.00	5.50
Medium	7.67	6.67	6.43	4.50
Large	11.50	8.80	8.50	8.40
Region				
East	6.25	9.67	10.25	5.40
South	8.33	6.67	7.75	6.00
Midwest	6.25	4.75	4.80	5.40
West	8.00	8.50	7.50	8.33
Age				
Less than 2 years	7.60	7.20	6.00	6.00
2-4 years	4.00	6.80	5.80	5.13
5 or more years	8.83	8.00	10.40	8.67
Ownership				
Public	6.44	7.20	5.20	6.29
Private	8.17	7.33	8.50	5.88

Table 27

Mean Number of Innovations Reported (Post-treatment)

	Treatment Groups			
Size of Center	A	B	C	D (Control)
Small	5.17	8.94	5.62	8.56
Medium	10.27	9.11	7.31	6.03
Large	6.75	10.82	5.35	6.13
Region				
East	4.96	11.14	10.63	5.40
South	8.57	13.22	4.81	5.88
Midwest	8.04	8.66	6.23	6.00
West	8.42	6.84	2.50	10.78
Age				
Less than 2 years	6.20	8.20	8.98	6.67
2-4 years	7.93	12.08	3.58	6.37
5 or more years	8.11	9.41	6.80	7.83
Ownership				
Public	6.60	6.63	4.78	7.08
Private	8.66	11.33	6.95	6.44

Table 28

Preferred Diffusion Techniques

	Pre-treatment		Post-treatment		Total	
Technique	N	%	N	%	N	%
Interaction with colleagues outside center	113	16.4	123	18.1	236	17.2
Visits to centers	110	15.9	123	18.1	233	17.0
Professional conferences	111	16.1	112	16.4	223	16.3
Informal contact with colleagues in center	81	11.7	90	13.2	171	12.5
Journal articles	70	10.1	54	7.9	124	9.0
Consultants	65	9.4	58	8.5	123	9.0
Abstracts	56	8.1	36	5.3	92	6.7
Additional training	28	4.1	22	3.2	50	3.6
Books	29	4.2	19	2.8	48	3.5
Formal meetings at center	17	2.5	26	3.8	43	3.1
Other	11	1.6	18	2.6	29	2.1
	691	100%	681	100%	1372	100%

These data support the trends noted in the chi-square tables. Those techniques which seem to be most closely related to innovativeness are interpersonal and involve contacts which are relatively informal and unstructured, and often reach beyond the innovator's home location. Preferred methods include interaction with colleagues located outside one's own center, visits to other centers, professional conferences, and informal contact with colleagues at one's own center. Interpersonal contact involving more formal diffusion techniques--consultants, additional training, formal meetings at the center--rank relatively lower. Of written materials, journal articles are preferred over abstracts or books, but all three rank below informal interpersonal contact.

As indicated in Table 25 and the appendices, Treatment Group B which concentrated on staff site visits to other centers generally reported a greater number of innovations considered than other centers. Treatment Group E included both interaction with colleagues located outside one's own center and visits to other centers--the two diffusion techniques rated as preferred by most respondents.

Treatment Group A also received these same staff site visits but in combination with consultation. Yet centers in this group reported fewer innovations considered than Group B. The consultant component contained elements of interpersonal interaction in more formal settings--formal meetings at the center and consultants. These techniques were judged as less preferable than informal interpersonal techniques. Perhaps the combination of formal and informal techniques had a tendency to stifle the innovativeness fostered by the informal interaction. However further research would be necessary to adequately answer this question.

The data from Table 25 and the appendices generally report that fewer innovations were considered by Treatment Group C than either Group A or Group B. Written materials seem to lead to fewer innovations being considered than personal contact. This finding would tend to bear out previous research findings.

IX. STAFF ATTITUDES AND ACTIVITIES

As described earlier in this report, the questions on Q1, Q2, and Q3 were designed in an effort to measure four variables thought important to a center's ability to consider the adoption of innovative practices. These concepts include (1) an awareness of what is happening in the mental health field, (2) a willingness of professional workers to consider change, (3) the extent to which staff are involved in planning and implementing new programs, and (4) the existence of a system to use information and consider change. The specific questions which were asked in an effort to measure these concepts are given in Appendix 1.

In this part of the analysis two major questions were posed. First, do the specific questions really seem to be tapping the same underlying construct within the scale for each concept, i.e., are the questions related to each concept more or less homogeneous with respect to the way a given center will answer them? Second, for scales which appear to be internally consistent, are differences found among treatment groups between Q1 and Q2 or between Q1 or Q3?

To investigate the reliability of the scales (i.e., does this set of items or questions really belong together, are they internally consistent), each item in a set was correlated with every other item in the set, and with the total score for the set, and also correlated with every other item not in the set. The complete intercorrelation matrices are found in Appendices 2, 3, and 4. The basic unit of analysis used was a center mean score for each item or question because of the fact that there was a variable number of respondents for each center. Center mean scores were correlated to produce the respective correlation coefficients for the various paired items (i.e., correlation between items 1 and 2 in Appendix 2 is .07). Scale scores (Awareness-TA, Willingness-TW, Staff involvement-TSI, and Utilization-TU) consisted of the unweighted total (sum) of the individual item means for the questions making up the scale.

As may be seen from the matrices in Appendices 2, 3, and 4, two of the scales, willingness and staff involvement held up quite well. The items within the respective scales were related to each other and generally not more highly related to items outside the scale. This was not the case in the awareness and utilization scales. Two items, one from each of these scales, were more related to the willingness scale items than to the items in the scales to which they were originally assigned. The two items, Item 1 of Awareness "To what extent are you interested in knowing more about effective practices elsewhere?" and Item 2 of Utilization "In general, how interested do you feel your center is in utilizing new information and ideas?" were moved to the willingness scale and the intercorrelation matrix was re-run. The following changes were made in the re-run: the Awareness and Utilization scales were dropped; Item 1 of the Awareness scale was added as Item 7 to the Willingness scale; Item 2 of the Utilization scale was added as Item 6 to the Willingness scale; the four remaining items or questions of the Willingness scale were reported independently. The complete matrices showing the new arrangement of data may be found in Appendices 5, 6, and 7.

Further analysis was made of the new seven-item Willingness scale and the Involvement scale. As described earlier in this report, each of the items within the scales were scored from 1 to 5 i.e., center averages obtained by item, and totals computed for each scale.

Means, standard deviations, N's and reliability (internal consistency) measures for these two revised scales are given in Table 29.

Table 29

Characteristics of the Revised Scales

	Q1		Q2		Q3	
	Willingness	Involvement	Willingness	Involvement	Willingness	Involvement
Means	28.19	17.58	28.03	16.78	27.68	16.95
S.D.	2.52	2.45	2.27	2.09	2.31	2.44
N	60	60	45	45	60	60
Reliability[1]	.84	.75	.78	.77	.78	.76

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[1] Cronbach's Coefficient Alpha

As may be seen from the above table, the scales are fairly reliable, with coefficients ranging from .75 to .84. The intercorrelations among the items within the scales indicate a fair degree of internal consistency within each of the two scales, but the coefficients are not so high as to indicate they are measuring exactly the same thing. In spite of the fact that different individuals responded at different times (Q1, Q2, Q3), there is consistency over time. The correlations between the Willingness and Involvement scales at the different times (Q1, Q2, Q3) were .60, .64, and .63 indicating a fair degree of relatedness between the two scales (data from Appendices 5, 6, and 7 respectively). Therefore it can be concluded that the revised Willingness and Involvement scales are internally consistent and reliable.

To investigate the second question, are there differences between treatment groups on these dimensions over time, analysis of variance (ANOVA) procedures were used. Tables 30 and 31 summarize the means and F-values for each group at each time the questionnaire was administered. More complete data and ANOVA results may be found in Appendices 8-15.

Table 30

Willingness Scale Regression Analysis

	Treatment Group				
Questionnaire Administration	A	B	C	D (Control)	F[1]
Q1	27.8	28.8	28.2	28.0	.42
Q2	27.9	28.0	28.2	Not Administered	.09
Q3	27.5	27.7	27.6	27.9	.12

Table 31

Involvement Scale Regression Analysis

	Treatment Group				
Questionnaire Administration	A	B	C	D (Control)	F[1]
Q1	17.8	18.3	17.6	16.7	1.13
Q2	16.5	16.5	17.3	Not Administered	.66
Q3	16.8	16.4	17.3	17.3	.41

---

[1] $F_{.95}$ = 2.78 for Q1 and Q3; $F_{.95}$ = 3.22 for Q2

As may be seen, no significant differences were found among the treatment groups on either of the scales indicating the treatments had no differential effects as measured by these scales.

Three questions of interest concerning the number of professional conferences attended, the number of mental health centers visited and whether or not the center had procedures to consider change were analyzed using analysis of variance techniques to see if there were differences among treatment groups. Table 32 below summarizes the results of the F-tests and Appendices 16 through 27 give more complete information.

Table 32

Summary of F-Tests on Three Items of Interest

	F-Values		
	Q1[1]	Q2[2]	Q3[1]
1. How many professional conferences have you attended?	.75	.79	1.08
2. How many community mental health centers have you visited?	.80	.55	.87
3. Do you have procedures set up to consider changes in practices at your center?	.18	.56	1.65
Value required to be significant at the 5% level	2.78	3.22	2.78

As may be seen, there were no significant differences among treatment groups on any of these items at any time the questionnaires were administered.

---

[1] Based on ANOVA for Treatment Groups A, B, C, & Control Group D

[2] Based on ANOVA for Treatment Groups A, B, C

There may be a number of reasons for the lack of significant differences in staff attitudes among treatment groups. It may well be that our measures were not sensitive enough to pick up subtle attitudinal changes. The "state of the art" in the mental health field in trying to adhere to a strict experimental design militates against controlling all factors which may have extraneous effects on the treatment groups. Nevertheless it is deemed important to keep trying to design good evaluative techniques which will measure treatment effects if they are present. In this case, center scores were calculated from a variable number of respondents (ranging from 2 to 12) at each center. In addition, the people within a center who answered Q1 were not necessarily the same people who responded to Q2 or Q3. On any rating scale such as this, it is difficult to control for differences in individuals' "internal norms." Most people tend to avoid marking the extremes of a scale (no importance, major importance) although there are exceptions. The perceptions of different people will also differ at any given point in time. A recommendation growing out of this study is that future efforts be made to control this source of variation by including in the analysis only those persons who respond at all points in time where comparisons are to be made.

Another problem is the lack of a really specific and quantifiable single criterion of the center's effectiveness. What is an effective center? There are no standards of certification at the present time, making objective judgment most difficult. Is part of the definition of an effective center one which has good procedures to consider change? If so, how do we define and recognize "good" procedures?

A related problem of criterion definition involves measuring innovation. Is the criterion the number of innovations implemented during a specified time? If so, is anything which is tagged an "innovation" to be counted, or should there be some criteria by which the innovation is to be rated? Is the criterion the number of innovations which have been considered, whether actually implemented or not? If so, what are the guidelines by which we count? Do we count equally 10 innovations which are considered in 10 different one hour sessions?

These questions are indicative of the problems involved in conducting this type of research in a non-laboratory setting. It has been the purpose of this project to maintain as much experimental rigor as possible while still providing service and assistance to the local center. In order to judge the effectiveness of this approach, attention must be given both to statistical analyses and to descriptive data before accurate conclusions can be drawn.

X. INNOVATIONS

The diffusion system described in this report was planned and developed around three major components: consultants, site visits and the written materials, *Source Book of Programs* and *Planning for Change*. During the development and initiation of the system it became apparent that a major component was lacking. Provision had been made for the *Source Book of Programs*, a rather comprehensive compilation of program descriptions. However there was no written method for disseminating other types of information or for insuring the timeliness of the information. The amount of work and correspondence necessary to produce the *Source Book* limits the ability to publish updated versions, and while it presents brief descriptions of new programs, it does not provide in-depth studies of exceptional programs or deal with non-programmatic information. The lack of a written diffusion technique of wider scope which could be produced periodically was identified as a major gap in the network.

This issue was subsequently discussed with NIMH staff. They too were aware of the need for such a publication and were interested in finding answers to the problem. Upon discovering this common concern, it was decided to expand the scope of the project to include the publication of a magazine, *Innovations*, as a collaborative venture between AIR and NIMH.

Innovations is designed as a user-oriented publication that highlights promising new ideas in the delivery of mental health services and connects these with tangible, practical methods for implementation. A major aim of *Innovations* is to develop an active dialogue with readers in order to strengthen the links between researchers and people engaged in the direct delivery of services. To encourage a broad exchange of ideas, *Innovations* has asked its readers to describe new service programs in which they are working, as well as to offer discussions of problems they are experiencing where assistance from others might be of benefit.

Since *Innovations* is designed as a user-oriented publication the contents are chosen to be in keeping with this philosophy. All information is presented with the idea of introducing the reader to innovative ideas with implications for actual use. Typically the magazine includes two or three in-depth features of innovative programs, plus departments which present a case study on change, brief reports of NIMH-funded research, summaries of programs reported by readers, synopses of current journal articles, book reviews, and a forum for dialogue on miscellaneous topics initiated by readers.

The decision that the content must be user-oriented and that users include people of varying experience and education led to other decisions about the magazine--the style in which the content would be written, the format in which it would be presented. Articles would be written in relatively popular, magazine journalism style. The format would also lean toward the popular magazine appearance.

The intent was to catch the reader's attention through appealing writing style and graphic design. The content must then back up this invitation with substantial, usable information.

Reader reaction was seen as an important factor in the further development of Innovations. In an effort to determine reader reaction, three evaluation methods were planned: (1) individual interviews with a small sample of mental health professionals, (2) review by a private consultant experienced in magazine editing and publication and in the mental health field, and (3) individual questionnaires to be filled out and returned by those receiving the first issue.

Both the individual interviews and the consultant's critique provided considerable favorable feedback on both content and appearance, plus many suggestions for improvements. The change from the first to the second issue, particularly in appearance, stems directly from these suggestions.

The first issue of Innovations, a special trial issue, was mailed to a limited sample of readers along with requests for feedback. These data were then used to provide guidelines for further development of the magazine. Response to the questionnaires indicated that the general reaction to the magazine was definitely favorable. There was a need expressed by the readers for increased communication of program and research information. In response to a question asking whether others might be interested in a program which the respondent had implemented, 94 percent (N = 133) replied that they thought others would be interested. However, most of these people had never written anything about their program; only 33 percent (N = 47) had ever prepared any written material for publication.

Another question asked whether the respondent was interested in what other mental health agencies had done about some particular problem. Of the 150 respondents, 67 percent (N = 101) replied "yes," 32 percent replied "occasionally," and 1 percent (N = 1) replied "no."

Readers were to suggest articles they would like to see in future issues. Here are a few topics which received several votes: developmentally disabled, evaluation, change process, children, funding sources, staff training, consultation, aged, rural programs, family counseling, civil rights and client groups, aftercare, rehabilitation, and psychiatric nursing.

A complete record of responses to the Innovations questionnaire can be found as Appendix G of this report.

Since Innovations was initiated rather late in the project, and then only on a trial basis, it was not included in any of the evaluations of diffusion techniques. Copies of the magazine were not mailed to any of the experimental or control centers during the time they were being studied for other portions of this project.

Evaluation of Innovations has proceeded along other lines, however. The mailing list has grown from 5,500 names to nearly 9,000. The following comments provide an indication of typical feedback:

> "I thoroughly enjoyed the first copy of Innovations and feel it is needed to enlighten people to the advantages of community treatment. Here at our Institute we are currently carrying out a mental health program open to innovations. Further, our program serves 700,000 people and involves 500 professional staff members. I would like for each member of our Executive Committee to receive a copy of Innovations."

> "I am thrilled that, finally, someone will be devoting a publication to existing and planned unique methods of psychiatric treatment and mental health programs in the nation. Thanks for the fresh air of innovation in the mental health field."

> "I would like to compliment you on your new publication which I am using in courses which I teach in mental health administration."

> "I have read your first publication, Innovations, and have found it to be interesting, informative, thought provoking; in short, valuable."

XI. CONCLUSIONS AND RECOMMENDATIONS

In a previous chapter, several hypotheses were posed which formed the basis of investigation. Each of these has been dealt with in detail in succeeding chapters, and now are summarized here as a recapitulation of findings.

Hypotheses and Findings

1. Interpersonal diffusion techniques are more effective for initiating ideas among staff in community mental health centers than written diffusion techniques.

Although data relating to this hypothesis were not statistically significant, there were trends in the direction of favoring interpersonal techniques over written techniques as the source of new ideas. Written materials, even when tailor-made for targeted audiences, are less effective in initiating ideas. However, it should be noted that such materials may be used with greater frequency at a later stage in the change process, when the innovator needs additional information or details on specific steps or techniques. The fact that many requests for written materials continue to be received months after original publication suggest that the long-range effectiveness of such materials may have been underestimated by these data. Further research on this hypotheses is recommended.

2. Centers which provide staff visits to other centers are more likely to consider innovations than centers which do not support such contact.

Site visits made by center staff to observe programs elsewhere, in combination with written materials, was the most effective diffusion techniques. Also, visits made to centers which had characteristics similar to the home center were more likely to be useful than visits made to centers unlike their own. While it is no doubt beneficial to observe a variety of programs, an increased amount of transfer seems to occur when situations are similar.

A critical factor in the success of the site visit technique may have been sharing the information with others. Following the visit, each visitor was required to tell other staff about the trip and to suggest ideas which might be considered at the home center. This was planned to maximize the possibility of information diffusion at the home center.

Another important factor was the presence of two or more site visitors. It was felt that by having two staff members observe the potential innovation, they might support each other later during the stage of planning and implementation.

3. Communication between a center and an outside resource (e.g., consultant, site visit) is more likely to result in innovation than communication and discussion limited to internal staff.

The data were not statistically significant but the trends were in the direction of support for the hypothesis. This trend is supported by reports of center staff collected in questionnaires and personal interviews, stating that the stimulation from a new person or center was a critical variable in their determination to implement some new program. Not only did this contact provide new information, it also allowed staff to compare their own activities with others and provided a reference point for making judgments about plans and innovation.

There is evidence that in several centers receiving written materials, groups of staff held discussions about planning for change or considering innovations. However, even in these centers the reported number of innovations considered was less than in centers receiving services from an external agent.

4. Centers which receive consultant visits are more likely to consider innovations than centers which do not receive such assistance.

The data tended to substantiate this hypothesis, though not to a degree statistically significant and not to the degree originally hypothesized. The most effective treatment consisted of a combination of site visits and written materials. When consultant visits were added, there was no related increase in innovations. Nevertheless, it is very likely that the influence of the consultant was much more pervasive and far-reaching than the other diffusion techniques. In fact, these services may have been of such a different nature as to make comparison with the other techniques difficult if not impossible. The results of the consultation may not show up quickly enough to be reflected in the number of innovations considered. Rather, the consultation may result in change in the interaction of staff, in approach toward planning and program modification, or in decision-making. Unfortunately it was beyond the scope of the project to investigate such possibilities, but this area certainly deserves further study.

Feedback responses from center staff after the consultations emphasized that the consultation facilitated communication within the center. The consultant visit brought various staff members together in one place at one time to discuss change and new information.

Staff reaction was also strong regarding the concept of homophily. All consultants in this project were actually employed by and working in community mental health centers. Staff strongly preferred consultants with backgrounds such as this to those who come from other fields or backgrounds.

5. A combination of several interpersonal and written diffusion techniques are more likely to lead to innovations than any one independent technique.

The data tend to support this hypothesis, but not to the extent theorized. Two components (written materials plus site visits) were more effective than one (written materials); however the addition of the third component (consultants) did not seem to add appreciably to the results.

It may be that the individual techniques themselves may be more critical than the total number or combination of techniques. Had resources been available to support more experimental groups, it would have been interesting to investigate various combinations of techniques, evaluating their effectiveness both singly and in combination with other techniques. This issue deserves further attention.

6. More favorable staff attitudes toward the change process are likely to result in more innovations being considered at the center.

This hypothesis was not substantiated by the data. Unfortunately, the measure of staff attitudes was unable to detect significant changes in staff attitudes in any group. The fact that differences were not detected does not mean no differences exist. It may well be that the measures used were not sensitive or accurate enough to detect changes in staff attitudes. This issue needs further development and research.

7. The larger the center, the more innovations will be considered.

The data did not support this hypothesis; size had no relationship with the number of innovations reported. It may be expected that, simply as a result of more staff, more programs and more patients, that more innovations would be considered. Yet this was not the case. Evidently size is not a critical variable in a center's interest in change or program modification.

8. The age of the center is likely to influence the number of innovations considered.

This hypothesis was supported at the time of the pre-treatment questionnaire; however at the post-treatment questionnaire the data did not show statistically significant differences. Pre-treatment data found that younger (less than two years) and older (five or more years) centers are more likely to implement new programs while those in the middle years (two-four years) report fewer innovations. Centers that are newly established will report virtually all new programs. Centers that have been operating many years may be considering new programs as they revise and update their services. Centers in the middle group may be at a point of program stabilization and less likely to consider change.

Post-treatment data (gathered approximately 16 months later) did not find these differences. It may be that centers had moved into different age categories by that time, making the original categories inaccurate.

9. Location and ownership may influence the number of innovations considered.

There was no support for this hypothesis. Whether a center is private or public, and whether it is located in the Northeast, South, Midwest, or West seems to have no relationship with the number of innovations reported. Geographic location and ownership do not seem to be critical variables in the center's consideration of innovations.

Beyond these specific hypotheses there are several general conclusions.

First, community mental health centers are interested in establishing a system of information exchange. Response to the services offered by the project indicates centers are interested in an information diffusion system. Requests from centers and other human service agencies for the written materials, Source Book of Programs and Planning for Change, far exceeded original estimates. There were also unsolicited requests from centers for consultants, site visits, or other assistance in information exchange. Personal interviews, questionnaire data, and letters with suggestions resulted in widespread agreement among such groups as center staff, national professional organizations, consultants, state and university training staff, and state and regional mental health service administrators for a useful system of information diffusion.

However, it is also clear that information diffusion cannot be taken for granted. Staff who have information to share are often unaware of diffusion networks and how to tap into them, and thus the information may not find a proper audience. However, when innovators were contacted and invited to submit information for widespread diffusion, the response indicated that staff are willing to provide and share information, as long as the diffusion channels are readily accessible and easy to use.

The comparison of alternate diffusion techniques revealed no significant differences in their effects on the criteria of number of innovations considered. However, staff reactions were highly favorable to most of the diffusion techniques and feedback indicated staff would like the network to be continued and expanded.

Site Visits

Site visits where staff had the opportunity to observe programs in action and even participate in the program if desired, appeared to be the technique which most frequently led to consideration of implementation. There may have been several details which contributed to the success of this technique. Staff were encouraged to visit programs underway at centers similar to their own. This was done to maximize the possibility of adaptation. If staff visited situations similar in terms of client background, geography, size, location, etc., the amount of translation necessary to adapt the program to the home center would be reduced and this should therefore lead to greater consideration of innovations.

In all cases, staff site visitors were requested to share information about the programs they observed with colleagues at the home center. The purpose of this request was to encourage dissemination of information to as large a group as possible. The site visits were designed to be of value not only to the visitor but to the rest of the staff as well.

The success of the site visit also might be due to some extent to the fact that this treatment allowed for individual discussion of the potential adopter's questions and doubts. In most cases two or three staff members traveled to visit the potential program and to meet with the innovators. They had an opportunity to learn of problems originally encountered and the solutions to those problems and to ask about how the program might be adapted to their unique situation. They were also able to discuss the innovation among themselves and to provide mutual support once they returned to their own center.

The report on the site visit from one center may sum up the reactions to the visit.

> "Their clinic has just gone through a merger experience like we're having, combining adult and child services. I was impressed with their activities and gained many new ideas. Seeing the program in action calmed my fears about such a task. In fact, it is exciting to visit staff who are ventureseome and who are reaching out to provide new services. Ever since we went there, we seem closer in thinking and practices than we did before the visit, and more harmonious . . . . I think the visit was a better learning experience than a special seminar or college course. I'm very enthusiastic for this type of learning/training."

Consultants

The use of consultants as a means of interpersonal communication led to slightly increased consideration of innovations. The consultants were trained and experienced in dealing with program modification and change. They were able to act as change agents and to work with the center on general attitudes and methods of managing change as well as to share information on specific programs or issues. The fact that the consultants served this dual role may have had an effect on the evaluation of diffusion methodologies. The consultants devoted only a portion of their time to a didactic process of relaying information about innovations. Their major effort was intervention with far-reaching implications for center procedures including such topics as staff interaction, decision making, implementation of new activities and their maintenance, etc. It is doubtful whether this latter activity, the major component of the consultant technique, was or could be adequately assessed by the post-treatment questionnaire. Rather it may be useful to look at a typical report from a center which received a consultant visit.

> "Our center had been holding an annual two-day brainstorming session since it opened four years ago. We discuss good ideas but usually nothing comes of it. However this year is the first time we've followed up on some of these ideas. When I think about why this is, I think it might be because of sitting down and talking with the consultant in change last spring. This time we had some suggestions on what to do with our ideas."

Five different consultants were used which resulted in five different consultant styles. Although an assessment of these different styles was beyond the scope of this project, it is likely that differences in style affected activity, content and outcome. It is clear that centers varied in the degree to which they used the consultant and in what they tried to get from him. It is also known that there were differences in the judgments the consultants made of the centers they visited and the degree to which the centers were receptive to the consultation. How these attitudes relate to "success" of the consultation is impossible to determine from these data but demands further investigation.

The consultant component in this project consisted of a two-day visit by the consultant to each of his assigned centers. Additionally, the consultants were encouraged to provide continued assistance to the centers by means of phone consultation or written feedback. This follow-up was conducted to a greater or lesser extent depending on the consultant. However, some centers reported that the two-day visit simply was not adequate. In these cases, it would have been most beneficial to have been able to offer a return consultation visit or visits. There seems to be little doubt that the availability of only one meeting between consultant and center staff was a limiting factor in the consultation, especially in cases of limited consultant feedback.

While reason argues that there must be differences between centers that consider many new practices and those that consider none or only a few, the demographic data investigated in this project do not provide this information. There seems to be no relationship between likelihood of implementing new programs and size of center, age, geographical location or ownership. It may be that the critical variables affecting information diffusion and the resultant change process lie in the area of attitudes, beliefs, and interactions rather than demographic data.

Although an effort was made to measure staff attitudes toward change, no significant results were obtained. It is likely that more sensitive measures need to be used or that different variables need to be isolated and evaluated.

Written Materials

Another major component was the development and dissemination of written materials. These included the Source Book of Programs: Community Mental Health Centers, Planning for Change, and later the magazine, Innovations. In general, written materials prepared for use by this project were well received as a means to facilitate the consideration of innovations. In addition, there is no doubt that written materials reached a much larger audience than the interpersonal techniques and that their impact was felt over a greater time period. Staff feedback indicates that these written materials were more helpful than might first be assumed from the statistical data.

Since all community mental health centers in the country received all written publications, there was potential for great variety of response. Yet nearly all comments were positive in nature and many requested the continuation and expansion of such a service.

> "Thank you for the Source Book of Programs. I'm really impressed and I hope you will solicit a second round of Source Book contributions. The staff here are very motivated to write up their projects in this format once they have seen the Source Book, and I suspect the effect would be similar in other places."

> "The Source Book is arranged so that it is easy to find needed material. The information on programs is clear and specific. The most useful aspect of the book for me is comparison--it allows us to compare our own programs against other similar ones throughout the country. After going through the Source Book I felt I was part of a very viable national mental health program."

Frequent requests for the Source Book of Programs and Planning for Change are still being received nearly two years following their initial availability.

The interest in Innovations has increased at a very great rate with no signs of tapering off in sight. The development of Innovations magazine was initiated in the latter months of this project and has enjoyed a most favorable reader response from the beginning. The first issue was prepared on an experimental basis and mailed to a sample of staff, requesting their feedback and suggestions. With the second issue, Innovations began reaching a national audience that has been constantly increasing. The following comments are typical of those received:

> "I am writing to comment on the usefulness of Innovations and to insure that I am on your mailing list. The way this issue helped me was in bringing material together in easy reference form, bits and pieces of which I had seen elsewhere, and in describing implementation of programs on which I had read general statements but not specific program descriptions."

> "I had an opportunity to see Innovations and was most impressed with the quality of the articles included. Each one seemed to be concerned with a timely issue and offered, naturally, innovative ideas and suggestions for dealing with that issue. The new and unique programs and practices described in your publication should be of interest to all practitioners in the field of mental health. I would like very much to have my name included on your mailing list and receive Innovations on a regular basis. I am already anticipating your next issue."

> "I am very impressed with Innovations and look forward to reading all your future issues--and perhaps contributing on occasion. It would be difficult, I think, for NIMH to spend its money more wisely than in its support of this publication."

Summary

The provision of information diffusion services and the development of a diffusion model were the major objectives of the project. It was an acknowledged fact that a good deal of information was being generated from research and program development projects but that the results of this work were often buried and thus could not lead to eventual implementation. The purpose of this project was not to add to that pool of hidden results, but rather to facilitate the diffusion of as much of that information as possible. In some cases this required translating the information from scientific jargon to easily understood language; in others it demanded summarizing lengthy documents into a few usable pages. In all cases and in all techniques the primary consideration was the staff member at the local community mental health center. Techniques and materials were designed to be of optimum usefulness in the everyday activities of the local center.

The project was successful in developing and demonstrating a national information diffusion network. Information was exchanged, contacts established, and innovations implemented. The users of the system themselves called for its continuation and expansion.

Personal contact as a means of information diffusion was felt to be beneficial and should definitely be continued in a diffusion system. In addition, written techniques have a definite utility. The widespread nature and large audience of this technique, plus a lower per capita cost, suggest that written materials should be included.

There are several aspects of the diffusion system which need further research. Certainly the long range effects of written materials need to be evaluated as well as the nature of the material. What form of written information is most likely to be used? What are the effects of length, style, appearance, content? Over what time period is the information most likely to be applied?

Attention needs to be devoted to the relative effect of a single diffusion technique as compared to a combination of techniques. Does the combination of two techniques double the probability that the information will be used? Or should a variety of techniques be available, ready to be selected according to the needs of the user? What is the effect of non-written media such as cassettes, films, videotapes?

What effect do staff attitudes and general environment have on the consideration of new information? What variables within the individual or user unit influence utilization of information? Can techniques be matched to users to optimize possibility of information utilization?

The whole area of consultation presents numerous unanswered questions. With as many consultant styles as consultants, it is difficult to determine exactly what it is that works or doesn't work with any particular client. However questions still remain. What kinds of client concerns lead to increased likelihood of change? What consultant techniques seem generally most useful to agencies considering program modifications?

Knowledge about information diffusion and utilization continues to establish a broad foundation for further effort. However enough questions remain to call for further research and refinement of diffusion techniques.

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SECTION II: CASE STUDIES AND APPENDICES

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CASE STUDIES

INTRODUCTION

The following case studies describe each of the centers which a consultant and an AIR staff member visited. The main purpose of the studies is to give a flavor of what the centers and visits were like, a flavor which statistical analysis does not provide.

Most of the information reported in these studies was obtained during a consultant's two-day visit to a center. The AIR staff member who accompanied each consultant took notes during individual interviews and group meetings. Also, the AIR staff person and consultant recorded their impressions of the center on cassette tape during the visit, and these tapes were another source of information. Some demographic data came from the National Institute of Mental Health. Finally, information came from staff members at the center. Staff filled out questionnaires before and after the consultant's visit. Also, those staff who visited other centers described their visits in reports or notes, which were used in compiling these reports.

Each of the studies uses the following format: (1) background descriptions of the center, including its history and a description of the area it serves; (2) an explanation of the services it provides and priorities it sees; (3) staff and organization, which also describes the management style; (4) a description of the consultant's visit to the center; and (5) a description of site visits made on the travel grants.

Statistics tend to focus on commonalities among a sample group. Case studies have the advantage of being able to show the uniqueness of each situation. The examples in this section portray a range of community mental health centers: urban and rural, large and small, young and old. The needs of their communities are different, and so are the internal situations at the centers. How these situations affect the problem of planning for change is the theme which links these case studies together.

Almost all of the centers visited reported problems which to some extent prevented them from functioning as effectively as they would like. These problems can be classified into three categories: (1) problems with the community, (2) problems with funding and administrative agencies, and (3) problems in staff interaction. The first category, problems with the community, is basically of two types: a lack of community support and a lack of outreach to various groups in the community. These two problems are likely to be interrelated. Other problems in this category are a tremendous population growth in the catchment area or a change of clientele.

Of the problems with funding and administrative agencies, the most frequent problem is, of course, funding or a lack of it. Related problems are pressure to reduce treatment time and conflicting pressures from various funding agencies about the kinds of services they want the center to provide. If the center is affiliated with a hospital or other agency, conflicts with the other group may be another source of difficulty.

The final category, problems in staff interaction, includes several related areas: lack of communication, dislike of authoritarian decision making, or poor organization. Any or all of these lead to low morale.

One center appeared to have done an exceptionally good job of planning for change. Some of the apparent reasons for its success include a conscientious program of outreach, a sympathetic community, a harmonious relationship with the state hospital, a progressive staff with roots in the community, an administration which is democratic as well as progressive, frequent chances for communication, and a healthy financial position. For many centers, of course, it is difficult if not impossible to achieve these conditions, but it may be useful to use them as goals to strive for.

ALPHA CENTER

Background

Alpha Mental Health Center, located in the middle Atlantic states, is a comprehensive mental health and alcoholism treatment program which serves an urban catchment area of about 150,000 persons. It is co-sponsored by the county and the city general hospital, and funded by the county. Its annual budget is in the range of $250,000 - $500,000. The center opened in October, 1970.

The community it serves has a variety of income levels, although it is predominantly lower-middle to middle class. A large proportion of the population is Eastern European in background, with Polish-Americans predominating. About 11 percent of the population is Spanish-speaking Puerto Rican, and three percent is black.

The community is very religious, and this seems to create one problem that cropped up regularly during discussions with the staff: Most of the people turn to the church for support when help is needed; they don't see the need for — or believe in — a mental health center. The staff are seeking ways of making the community aware of the services it offers and also attracting clients to the center. Specifically, the staff note the need for outreach to the Spanish-speaking segment of the community and more effective ways of handling referrals of children by the schools. In addition to the passive resistance from the community, active resistance to the center seems to be coming from the medical community, whose members feel threatened by any government "encroachment" on the practice of medicine.

Despite the apparent lack of community support, the center seems to have a fairly stable funding situation. However, this situation may change, because the county board member who sponsored the founding of the center, and who has supported it ever since, was recently defeated in community elections. The opposition to the center by the physicians, particularly local psychiatrists, could also play a crucial role in the center's future.

Services

Alpha Mental Health Center seems to be moving away from the medical model, and even from the concept of mental health services. They are becoming more interested in providing people with experiences in living — new ways of handling problems and coping with life situations. As yet, however, the staff hasn't implemented this in practice as much as they have in their thinking. In general, the staff does share this philosophy, and they take it into account when they interview new staff.

Because it evolved from a children's clinic, the center has a strong history of providing direct services. As far as treatment approaches are concerned, family therapy is definitely stressed. A big effort is made to involve the whole family in finding solutions to problems, especially in the area of alcoholism treatment. These areas — alcoholism and child services — are particularly important services of this center. In addition, the basic services — outpatient services, inpatient services, emergency service, and partial hospitalization — receive much emphasis. Increasing importance is being given to the program for community consultation and education, which is specifically devoted to preventive educational seminars, lectures and discussions in schools, industry, clubs, agencies, and the community at large.

Staff and Organization

All components of Alpha Mental Health Center are staffed by professionals. They include psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, rehabilitation counselors, psychiatric mental health aides and paraprofessionals. All key members of the staff have positive attitudes toward the project and seemed willing to consider change.

The clinical director's style of management tends to be informal. Although unit chiefs meet weekly to discuss problems, suggest solutions, discuss issues, and make recommendations, the director prefers to make decisions based on informal discussion. The center encourages all levels of staff to visit other programs. Lower echelon staff has open access to upper level staff and a chance to be heard. The visiting consultant commended the center on the degree of communication among the staff. "I've never been to a community mental health center or other psychiatric facility where I've been so convinced that lower echelon staff have access to upper level staff and a chance to be heard," he said.

Current Situation

The center's biggest problem at this time is gaining more community support. The staff is approaching the problem in several ways: having an open house to introduce their alcoholism program; working through the schools to provide indirect service; and hiring staff members who are of the same ethnic background as the community they serve.

A related problem is finding ways to meet the needs of the growing minority of Spanish-speaking Puerto Ricans in the community. Staff members also expressed some concern about coordinating the center's day care program and the hospital's in-patient program.

Consultant at the Center

The center was prepared and organized for the visit. An orientation meeting with the administrator started things off. The consultants then met individually with the medical director, clinical director, clinical coordinator, director of the day hospital, director of child services, and coordinator of the alcholism program. The first afternoon was spent in a group meeting which included, in addition to those named above, the director of consultation and education and the nurse coordinator of the inpatient unit. The second day of the visit opened with another group meeting, which was followed by meetings with staff representatives from the various services.

In general, the consultant listened and then asked probing questions. At the end of each day, he gave feedback to center staff and was open to questions and comment from them. He emphasized that his role was to assist and advise the staff on the process and problems of change.

In a follow-up letter to the center, the consultant noted that the following areas were identified by staff members as those in which the center might consider change:

1. Include "change" on agendas. The idea of periodically making "change and program evaluation" an identified part of the agenda at staff meetings would allow change to be recognized as a legitimate item for discussion and planning. It would also avoid relying on chance as an occasion for moving onto that topic.

2. Increase staff's community awareness. In one of the group meetings, it came out that many of the staff do not know very much about the community they serve. Because the center wants to be a community agency — meeting the needs of the Spanish-speaking population was mentioned several times as a specific concern — the director may want to explore how the staff can learn more about the history of the area and the cultures of community groups.

3. Integrate consultation and education services. Staff members needed to know how these services fit into the overall center goals and philosophy, how they should be organized and coordinated, how they might be used as a focus for planning and evaluation, and how they relate to current efforts at increased community outreach and involvement.

4. Expand data collection. Staff may view this as merely a tool of the administration. Therefore it might be desirable to explore staff attitudes toward data collection. This might help staff to see that they can use data collection to obtain information for their own program planning.

5. Improve attitudes of practicing physicians in the community. Certain programs may be vehicles for changing the attitudes of the medical profession toward the center. Examples are geriatric services, a well-child clinic, or

prenatal and postnatal education. If physicians have good experience with a program not identified with mental illness, it may influence their attitudes towards the center's other activities.

6. Learn about the state hospital. Many of the staff know little about what goes on at the state hospital and a visit to the state hospital by some staff members might be worthwhile.

7. Improve the school referral system. In dealing with the schools, it seems useful to begin dealing with the referral system in September in order to minimize problems in May and June. Also, a summer activity program for "normal" kids might be useful in changing the attitudes of community members toward mental health.

Visits by Center Staff

The clinical director had originally expressed an interest in visiting a community mental health center in Fajardo, Puerto Rico. Because of the growing Puerto Rican population in his catchment area he felt it would be useful to learn more about where the Puerto Ricans are coming from. This travel was not possible under the grant, however. Sometime later, the administrator and one staff member visited a mental health clinic in central Florida. Although they indicated that this center had been selected because it served a large number of Spanish-speaking clients, they mentioned nothing about programs for or needs of Spanish-speaking persons on the site visit report form. Rather, the form indicated that the most interesting aspect of the visited center was the working relationship between the day hospital program and the inpatient unit. The administrator indicated that they were "particularly impressed with the day hospital program, specifically with the excellent working relationship this program had with the inpatient unit."

After the site visit, a special meeting for the six department heads and unit chiefs was held and the administrator described general staff reaction to the program as favorable. The administrator and the medical director indicated that the visit was extremely useful, that innovations observed at the center were very compatible with the needs of their center, and that their center has already implemented practices that were observed during the site visit. However, three other staff persons said that they, personally, had learned nothing about the other center's programs, and to their knowledge, no new practices had been implemented at their center as a result of the visit.

BAKER CENTER

Background

Baker Center, situated in the foothills of the San Francisco Bay area, is--physically--a model health facility. The center, which opened in June 1970, is in a residential setting and adjacent to schools which are attended by some of the center's residents. The attractive facilities, which include a gymnasium and an ample supply of spacious offices, helps to create a relaxed atmosphere among employees and patients alike.

The center operates with a full-time staff of 56 employees. The immediate catchment area of 169,066 is racially and economically mixed. It is a publicly funded agency with an annual budget ranging close to one million dollars.

Founded in the 1890s, the center was originally an orphanage. It had a very conservative board of directors who were primarily Methodists. Their main objective for the center was the custodial care for homeless youths of all ages. In the mid-1960s, the county planning agency recommended that the center change from a custodial care center to a treatment center. This suggestion was controversial -- it resulted in half of the board of directors resigning -- but the change was implemented.

Many changes were incorporated as the new center was formed. The center concentrated on teenage youths instead of children of all ages. The facility started to accept patients who were more disturbed and whose emotional problems were more severe than those of the homeless children who were the former charges. In addition, there has been pressure to shorten the stay of each patient from the previous average of four years. Average stay is now 22 months.

The community surrounding the center has a mixture of high and low income residents. Approximately one-third of the residents are minority. But the cost of treatment ($1,800 per year) separates this center from the community. The center accepts individuals from private concerns who are able to afford the fees, while many county referrals are sent to foster homes and custodial care homes, which are cheaper facilities. For the past few years the center has been operating below full capacity because of the high costs.

The center's other services also fail to meet the needs of the community fully. A shortage of funds and a lack of county cooperation results in a small range of services. The original scope was to become a multi-service agency, but now the strong point is the provision of residential treatment.

Services

Its original application stated that the center would be fully developed, with other services to be funded from various sources. But due to the lack of general coordination of state funds, and of support from the county, the original "master plan" which called for a comprehensive mental health agency, has been greatly diminished to an emphasis only on residential treatment.

Staff and Organization

On the whole, the staff is a concerned group who are thorough in their performance. On the unit level, they have the ability to act on their own, but divisions above the unit level do not have this freedom. At the agency level, important decisions are made by the director, who acts with the counsel of his two top aides, the center's psychiatrist and the chief social worker. There is little or no input from the rest of the staff.

Staff members cite instances in which a concerted planning effort was made for change, but with little constructive results. They also cite examples in which little or no planning resulted in ineffective programs.

Staff express varying attitudes about the administration's performance. Some see the "freedom" given to units more as a lack of supervision from higher levels. Low morale because of what some staff perceive as administrative inefficiency also appear among some members. Low salaries, particularly among child-care workers, also contribute to lowered staff morale and high rate of turnover.

Current Situation

One problem the center faces is pressure to shorten the length of treatment. Having been an orphanage, the center still retains the belief that residents should stay a minimum of four years. Even though the average stay has been cut to less than half this time, there is pressure to cut it even more.

Also, the expense ($1,800 per individual per year) is high. Many clients cannot afford this amount, and because the center relies on private fees, it often does not operate at full occupancy. The occupancy rate was reduced further when many referrals from the county were placed in cheaper facilities. A consequence of this action was that county supervisors have been losing interest in the center and withdrawing promised funds.

One new type of client the center is receiving is the disturbed teenager. This client requires custodial care, which the center is unused to. Further, such clients have been difficult to place after treatment.

Consultant at the Center

The first morning the consultant met with the director and his two top aides, and then with two small groups of staff members. After the small group meetings, all participants gathered together for one large meeting. Later the consultant met again with the center director and his two aides.

The first meeting with the director and his two top aides dealt with the background, philosophy, and needs of the center. Discussion focused on problems of funding, building, and the center's operating procedures. The director expressed needs for a girls' home and for programs geared to shorten treatment time. Nothing was mentioned about internal problems.

One of the small group meetings was directed toward the administration and their procedures. This meeting involved the "new blood" of the center: one child-care and two social workers. They mentioned there was a lack of coordination of efforts starting at the administrative level. They said that it is difficult to initiate change at the administrative level, whereas this difficulty does not exist at lower levels. The day-care program was a "flop," the three said. Even though there is a great need for a girls' home, nothing had been started. They felt the agency is not doing enough and could be doing more.

The second major point these three brought up was the problem of communication within the agency. There is quite a bit of friction about the way the lower staff receives communication. For example, even though the consultant's visit had been arranged well in advance, the staff had found out about it only two days prior to the scheduled meeting. They had to rearrange their own schedules in order to make the meetings. They felt that the agency could be doing more, with better defined goals, through increased staff communication.

The third group had an entirely different viewpoint concerning the problems at the center. They felt the staff was free to implement change; when ideas were presented, they were acted upon. They had a general feeling of confidence and they had no qualms about the center. This group comprised a social worker, a recreational therapist, and a teacher. These three had been employed at the center for a minimum of seven years. They were in an entirely different mood than the second group.

None of the previously mentioned information was brought up in the afternoon meeting, a combination of all three groups. The staff was quiet, and the three top administrators were defensive throughout the whole meeting. The director and psychiatrist kept defending the center and reiterating what the center was involved in. Even though the consultant focused the conversation on change processes--how, when, where, and why to implement change--the director returned with a monologue on why things were that way and not on how he would implement change. Even though everyone had had something to say in the morning meetings, they were relatively silent for the afternoon session.

The final session again involved the director, his aides and the consultant. The consultant related his observations of the center and gave his comments. The three seemed more relaxed at this meeting but were still defensive. They were more open to listening and provided some good feedback on points made. Discussion ranged from the hiring of minorities in key positions to streamlining some of the programs to make them more effective.

The consultant was effective in communicating with the staff and in not exerting any undue pressure at any of the meetings. He talked very little and prompted the audience to respond. During the discussions, the consultant focused on change and encouraged the staff to do the same. He made sure of total participation from everyone.

Visits by Center Staff

By choosing centers within a limited area -- Southern California and Arizona -- the staff was able to visit seven centers.

Site Visit 1. This is a residential treatment home where boys are diagnosed and treated therapeutically. The average length of treatment is four and a half months. Afterwards they are transferred to any one of ten smaller group homes owned by the center.

The visitor was interested in the remedial reading courses conducted by the center. The instructor made good suggestions regarding diagnosing problems which occur at Baker Center. Some of these suggestions were implemented at Baker. The use of group homes appealed to the visitor; however, the worker-patient ratio, which is one adult for eight adolescents, is too large for Baker because of the different types and the severity of psychological problems their children exhibit. Also, at the visited center, the boys are placed by the welfare and the probation department, a different procedure from Baker.

Site Visit 2. This is a residential treatment center for girls, ages 13-16. Included in the program is an educational and recreational program, social services program, and residential living quarters. The center admits emotionally disturbed girls.

The staff works to help each girl accept and understand the reality of her situation and to be responsible for her own behavior. Their methods of treatment include group and individual psychotherapy, individual social work, and group living situations. There is a standard campus-wide point system under which the girls earn all their spending money and their privileges. The point system seemed to eliminate pettiness and competitiveness within the various parts of the home. The classroom structure and discipline was looser than would work at Baker Center, because the girls at Site 2 are less severely disturbed.

Baker's staff did not react when the site visitor reported on the trip. The visitor described the reaction from the staff as a "wild outbreak of apathy." The meeting was small, with a little turnout from the lower staff. The staff did not seem to be aware of any need to implement changes in the present program. The visitor felt that if the lower staff had more direction and confidence, and if they felt they were an integral part of the treatment program instead of just "caretakers," they could effectively change the program.

For the site visitor, however, the visit to Site 2 was very enlightening. The visitor was given a fresh perspective to interagency problems and was given new ideas of how to handle them.

Site Visit 3. The program observed here, a community mental health center, was the day school for disturbed children, grades 1-12. The school is designed for students who cannot adjust to regular schools. These students are referred to the agency by their local school district, which pays $225 per month for each student. Classrooms are staffed by teachers and counselors who are advised by the treatment team leader, a social worker or psychologist.

The staff seem a professional and progressive group, who make the maximum use of the minimal funds they receive. The average length of stay for each student is two years; the agency claims 100 percent successful return to the public school system. The psychologists work daily in the classroom conducting group and individual psychotherapy. This is the greatest strength of the program.

The visitor particularly liked the discharge procedure. In this, the team speaks directly to the prospective public school teacher and administrator about the student and makes specific suggestions as to placement, extra help for him, etc. The visitor thought that Baker Center should start a residential center, including a classroom building at the central location, with children housed at nearby satellite homes.

The report of this visit was given at Baker's regular staff meeting. The 30 staff at the meeting were generally neutral. They felt that the satellite home plan was worth considering, but the immediate priority is Baker's plans for a group home. They did propose to discuss the matter further. They also felt that they have already overcome many of the problems the visited center is experiencing.

Site Visit 4. This site is a school designed to provide a desirable setting for emotionally disturbed and mentally retarded children and a few adults. There was no special program that the site visitor wanted to observe. He got an overview of the entire program.

The visitor thought the school's vocational training program would be especially helpful to the youth at Baker Center, since the visitor felt that Baker Center needs a better vocational training program for its adolescents. Site 4 also uses a system of student worksheets, which allows the writing of treatment goals for each student. This system seemed useful to the visitor. These suggestions were well received at the regular staff meeting. Discussion is being stimulated in the areas mentioned.

Site Visit 5. This is a girls' residence. The community consists of two houses, each with a capacity of six, and a cottage, used as the headquarters, which has a capacity of 16. Most of the girls attend nearby public schools. Tutors, volunteer aides, and a counseling center are available to help the girls. The director is very involved in working with them and has a "case aide" liaison on staff to further assist them.

The community houses offer a different atmosphere than most houses of this kind. They resemble a campus. Thus, a girl may be able to "graduate" from a community house, as opposed to serving out her term at an institution. The supervision is somewhat loose, which would not be useful in Baker's situation because Baker's cases have more difficult problems.

Observations from this site were reported at the regular staff meeting. The staff was interested in learning about the programs, but there was no action taken to implement any new programs.

Site Visit 6. This has the same kind of campus setting as Site 5. This facility houses approximately 115 children and has excellent recreation facilities which include swimming pools and tennis courts. This site admits only children of one religious group. It has its own remedial school and also makes use of the public school system. Its programs are similar to Baker Center, but it is smaller. There is a large staff and a good volunteer program and it admits a variety of patients with special problems but not mental retardates.

One feature the visitor noted was that various staff members use personal skills that they are highly proficient in. The visitor felt that Baker Center should make better use of its staff who have special skills. The visitor also felt that Baker Center should have a larger and more comprehensive volunteer and training program.

These points were discussed at a special meeting, which included the director, assistant director, and some house parents. They showed little interest in these programs and stated that Baker is a residential center, therefore, a group home was not an interesting tangent. However, the visitor said she received new insight on these programs because of her personal observation of them.

Site Visit 7. The final site visited only accepts boys who are older and more delinquent than disturbed. Its basic structure is very rigid and militaristic in nature. The visitor observed the special education classroom. The instructor teaches all levels of math, English and social studies to eight or fewer students and she uses groups and peer control to solve classroom behavior problems.

The use of learning centers on wheels and the use of quiet rooms as an alternative for highly distractable students were seen as possibilities for Baker Center. But because Site 7 is an institution for delinquent boys as opposed to the emotionally disturbed, no interest was stimulated at Baker Center for change.

CLOVIS CENTER

Background

Clovis Center is in a town of 30,000, but the area it serves consists of six counties, as one staff member put it, "on the edge of Appalachia." These counties have a combined population of nearly 200,000 people and cover a total area of close to 3,000 square miles. As would be expected from the location, the center's patients are fairly poor, and the poverty of the area also creates the problem of raising local money.

The center is the outgrowth of a small child guidance clinic, which operated out of an old house. In 1967, it was incorporated as a non-profit psychiatric facility, and the following year it moved to its present site, a $500,000 plant. Its annual operating budget, over $500,000, supports a staff of 41.

The board of directors is composed of members from all six counties. It is a strong force in determining center operations. The board insists that the center care for everyone in the catchment area "who makes a squeak," as the consultant noted. This means a strong emphasis on outpatient care. One of the center's problems — its financial problem — comes from the fact that only 30 percent of its funds come from the local counties (through a mill levy). The rest comes from the state (40 percent) and federal (30 percent) governments, each of which has its own conflicting priority for what the center should do.

The center also has a problem in that federal regional inspectors have been critical of certain center programs, to the point of suggesting that federal support be terminated. This situation has of course put tremendous pressure on the center. A third problem, although one that may not be recognized by the center's board and administration, is that staff morale is low to the point of discouragement.

Services

The center has no overall, uniform philosphy. Its leaders vary in background and orientation; and have different philosophies. In fact, the center's services seem to result less from a coherent statement of goals than from the pressures of the funding agencies. The local board, for instance, wants patients cured and cured fast; therefore the center stresses outpatient service, devoting from 70-80 percent of its time to that. Inpatient service is handled through various state hospitals, but because the state is moving to shut down some of these units, it is urging the center to stress aftercare services. The federal government wants work done in the area of prevention and consultation.

In the last two years, the center has introduced two new services: a 24-hour crisis hot line and a children's diagnostic and treatment team.

Staff and Organization

The center is directed by a triumvirate: the medical director, who is a psychiatrist; an executive director, whose background is in social work; and a director of clinical services. Lines of responsibility between these positions are unclear. The three say that they make decisions jointly, with the approval of the board, and that the board is not sympathetic to staff participation in decision-making. The board believes that staff members are primarily employees.

The effect of this attitude on the staff is obvious. In the last four years, there have been 31 resignations. The current staff, which come from a variety of backgrounds, are clearly dissatisfied. They feel they are usually not consulted about decisions and, even when they are, their recommendations are overridden by the three administrators. It was at the insistence of staff that a director of clinical services was added to give the staff more input into decisions. In practice they have not had any more input, and having three directors instead of two simply makes it harder to assign responsibility for any situation.

Regardless of this situation, the directors believe that most (70-90 percent) of the staff is interested in innovation and willing to take on new programs and duties. The visitors judged a moderate willingness to try new programs. The visitors also noted that the staff seemed to have slight awareness of effective programs elsewhere and only a slight involvement in planning new programs.

Current Situation

As mentioned earlier, the center feels caught between the conflicting priorities of its three funding sources—federal, state, and local. The federal inspector has been critical of the center for several years. Criticisms have been of the lack of prevention and consultation programs, and also concern the operation of inpatient and satellite centers. In particular, the criticism seems to be that community mental health programs have not reduced the state hospital population. (It is also possible that personality clashes have entered in.) These criticisms have led to the suggestion that federal funds be cut off.

The state's main concern is aftercare. The state has made moves to close units in the state hospitals without providing local communities with funds to establish aftercare programs. The center expects a large increase in the number of aftercare patients it sees.

Finally, the center faces pressure from the community, which wants direct service programs that show tangible benefits. Because local funds come through a mill levy which must be passed every five years, the center is under constant pressure to prove its worth to the community. Furthermore, two of the counties have not passed the levy, and the center has to determine what services to provide these counties.

With all these problems, the staff feels that however they move, they bump against federal, state, regional, or local pressures. In fact, the move towards decentralization seems to have complicated the situation, as well as reduced funds. The major problems facing the center, in summary are:

1) Resolving problems with federal investigators so that continuity of funding will be assured;
2) Establishing a firm local funding base; and
3) Resolving personal and programmatic problems within the staff.

Consultant at the Center

The consultant, director of a midwestern mental health center, and the AIR representative met all morning with the three directors. At first, the visitors had to deny several times that they were inspectors as they explained the purpose of the visit.

The directors explained the center's problems, particularly in relation to the federal regional personnel, and emphasized the cross currents in which they felt caught because of conflicting priorities. The consultant, who is a member of the National Council of Community Mental Health Centers, believed that the suggestion to terminate funds seemed unjustified. He offered to bring the matter to the attention of the council, which might serve as a mediator and arrange an appeal procedure, such as another site visit.

In general, the tone of this discussion was defensive. The directors seemed to be justifying their position and the center.

The decision-making procedures of the center were also discussed. The directors noted that staff members had little voice in this at the behest of the board.

The afternoon meeting was with four staff members, all program heads and all about 30. The dissatisfaction felt by the staff soon became clear. The program directors took different approaches to the problem. One, who was very vocal, felt frustrated and resentful; another tried to go around the problem and work on his own; a third was between those approaches, and the last was too quiet to have his views ascertained.

During the first part of this meeting, the consultant listened to their views, made supportive comments, and asked clarifying questions. Toward the end of the afternoon, the program directors began asking questions about how various matters where handled at the consultant's center. They were very interested to hear how that center is run, how staff is involved in decision-making, and how conflicts are worked out.

Visits by Center Staff

A staff member visited a regional mental health center in the southeast United States. The center serves four adjoining counties. It is unclear exactly why this center was chosen or why this staff member was selected to make the trip. The likely reason, in addition to the center's having a regional catchment area, is that several programs fit in with the Appalachian center's needs.

In his four days there, the staff member observed four programs: a satellite clinic, a day hospital program, a program for teens, and an aftercare program. On returning, he filled out a form with his reactions to the programs. The aspects of the programs which he felt might be usable at his home center included: use of a team approach in satellite clinics, use of paraprofessionals, a court of appeal available among social service agencies, and the requirement that patients who are discharged from mental hospitals must make an appointment with the mental health center. A weakness he noted was ambiguity of leadership and responsibility. He recommended that some components of these programs be adopted in his own center, noting that they could be added to existing programs.

In addition, the staff member wrote a several-page report for his home center which described the background of the visited center, its staffing and services, and the strengths and weaknesses of its programs. In the discussion of strengths, he paid particular attention to the administrative structure and staff morale. He noted, "The informal structure is a strong point. The staff, without exception, is able to talk over their personal and professional problems easily with the psychiatrist and administrator. It would appear that the morale of the staff is high." Further, he noted that the administrator was "highly successful and effective, and "had respect of both agency staff and the community." He thought that the center was accepted in the community. Weaknesses, in addition to ambiguity of responsibility, included lack of formal staff meetings or inservice training, poor coordination between hospital and center because the hospital lacked a psychiatric unit, and overuse of medication, especially on aftercare patients in rural settings.

It is uncertain whether the home center discussed the visit formally. In a follow-up questionnaire, the visitor termed the visit "extremely useful" and the practices observed "very compatible" with those at the home center. But the two other staff members who returned the forms thought the visit was of little use and the programs only slightly compatible. In any case, none of the programs had been adopted.

DOVE CENTER

Background

Dove Center is a medium-sized urban center located in the Northeast. It is next to and has direct affiliation with a large medical center. Dove Center serves the entire county, which has a population over 180,000, and provides mental health services for another comprehensive medical center located in the catchment area.

Originating as a suicide prevention line in the Department of Psychiatry of the medical center, Dove began operation as a community mental health center in 1967. At present, the center is located in the old hospital buildings. The space is overcrowded, and staff are scattered among various buildings. There are no formal or scheduled procedures for exchange of information among the staff serving the different parts of the center. Only key or administrative staff hold regularly scheduled meetings. The center is scheduled to move into a remodeled part of the hospital complex within a year; staff hope this will relieve the overcrowding.

Dove Center is located in a suburban area that grew after World War II. The majority of the population is white; the economic level is lower-middle to middle income. People moved here to escape the ghettos of the city. No sense of community or tradition has been developed, and residents have no cultural ties to this bedroom community. The pressures and needs of the community may stem from the rootlessness and disillusionment of its residents. The community does not seem to be facing up to its current problems of isolation, drug abuse, and high unemployment.

According to center staff, the community is not really aware of the existence of the mental health center. A community mental health board was created in an attempt to gain support in informing the community about the center, but without success. The board has now been discontinued. The staff does not feel substantial ties with the community, and one of the goals of the new director has been to increase community involvement.

Funding is beyond center's control. The center is one part of the total budget for the medical complex and this has placed limits on the availability of funds in certain areas. The center received an NIMH planning grant, but 30 staff positions remain unfilled because of a freeze placed by the county on hiring new personnel. The relationship of the center to the medical complex constitutes one of the major problems of the center. The restriction on hiring has resulted in a cutback in the number of staff by 40 percent.

Services

Dove Center provides most of the services of a comprehensive mental health center. Because of its attachment to the medical center, there is an overlapping of inpatient services. Special services include a drug abuse program and a priviate child care facility for emotionally disturbed children.

The center does not operate on a purely medical model. The psychoanalytic treatment approach is well represented because of the high number of psychiatrists of an analytic philosophy working at the center. The psychiatrists, who are primarily the chiefs of the main services, tend to follow the traditional medical model and continue to stress the initial hour long interviews with clients. However among other levels of staff, group work is a more favored treatment approach than individual analysis.

Dove Center is coming to realize that indirect services are as important as direct services. Although direct services continue to be stressed, there have been increased efforts in the area of consultation and education. Compared to other staff members, psychiatrists have the most difficult time moving from the medical model to the community model. This difficulty is based on the training they received, not on the center per se. Thinking in terms of community needs for indirect services rather than direct services to individuals has not been completely accepted by this professional group at Dove Center.

The consultation and education program involves all social workers and psychologists and some nurses. They meet once a week to decide on the projects on which they wish to work. Unfortunately, there is little community organization. Because the community mental health board was not acknowledged by the county board, it was discontinued. The program is also limited by the high demand for direct services.

Staff and Organization

At the time of the consultants' visit, 40 professional staff were employed at Dove Center. The selection and titles of the staff are based on civil service specifications according to discipline. Because of organization and the fact that the center is understaffed by 40 percent, staff are involved in more than one service at the center. This situation has led to informal communication among the different programs and increased the sharing and use of information about the various practices.

The director and the chiefs of the main services represent the key staff at the center. They also form the executive council, a group decision-making body. This upper level group is comprised of psychiatrists. Middle level staff consist of social workers. Lower level staff are mental health workers and paraprofessionals.

As noted, psychiatrists at the center use the medical model. Another group of professionals, social workers, have a strong identity with their profession and look to it for their standards. They are an active self-initiating group with a high degree of professionalism and are dedicated to their work. As would be expected, this group has had an easier time in accepting the community model and in developing programs to fit the community's needs. The changes they have instituted have come about informally, usually through individual initiative.

Current Situation

The director of Dove Center had been there only three months at the time of the consultant's visit. His background was in administration rather than in mental health. The executive council, formed during the absence of a director, had assumed administrative decision-making responsibility. The director indicated he would like to depend on the council less in making administrative decisions, using it instead as a communication and advisory group.

Staff are well qualified. They like their work but feel overworked because they are understaffed. They also are overwhelmed by the politics of dealing with the hospital and county and by the limitations the civil service system has placed on them. These problems make the staff feel helpless about implementing new ideas. There is good communication among the staff and a high degree of awareness of new ideas and practices, but they feel that any change is limited by their relationship with the hospital and county. To most of the staff interviewed, these negative implications outweigh the positive ones of stability and resources that being part of the county health system provide.

Consultant at the Center

During the consultant's visit, individual meetings were held with the chiefs of the main services and the staff. During these meetings the consultant mainly listened to staff explain the current needs and problems of the center. The consultant summarized these discussions at a group meeting and in a follow-up letter sent to the director.

During individual interviews with senior staff members, the principal need expressed was for more staff members. Because of their relationships to the hospital and their own lack of authority, staff could not move to meet this need themselves.

The relationship with the hospital has created certain pressures at the center. The consultant did not encourage discussion about this relationship because it was not likely to change. Rather, he focused discussions on areas where situations could be changed by greater staff awareness or involvement. The type of questions the consultant asked staff members included:

1. If you started all over, what would you like to do differently?
2. What direction do you want your program to take?

These questions stimulated staff to think about what they would like to do differently and alternative ways of how to accomplish these changes. The consultant talked very little. Almost all comments focused on the change process and an identification of the areas in which change could take place.

One staff member thought the best way to change was in response to NIMH inspection recommendations which the county would adhere to. Another member believed change had to be informal, based on individual initiative. He thought formal procedures would result in too great an involvement in the existing bureaucracy. One staff member wanted more autonomy, less control by the hospital and the county.

Staff seemed to think of change in terms of adding services to their already overburdened schedules, and resistance to change stemmed from this attitude. To think in terms of change as eliminating some services and changing existing services to meet the needs of the community would mean an evaluation of the total program. Because the center did not seem prepared for the total rethinking process, the consultant focused on change at the individual level.

Staff expressed a need for a clearly identified inservice training program. This program could be limited to the center or integrated with other agencies. Several staff saw a need for greater use of volunteers.

In terms of services, current needs included improvement of geriatric services, a more specific delineation of aftercare services, and the formation of a night hospital and a halfway house. Staff also want greater impact in the community through greater use of their consultation and education program. Finally, they would like formal evaluation procedures of their programs. Budgetary limits had prevented this.

A small group meeting was held at the end of the visit, attended by members of the executive council and the director of the center. The consultant gave a summary of his impressions and suggestions, focusing on change.

One method of change identified was exploration and further definition of center policies and philosophy. These discussions could take place in one of the retreat sessions occasionally taken by senior staff members to discuss other aspects of the center. This method could result in the movement of staff from behind the desk and into the community, once policies and philosophy had been identified.

The consultant mentioned that a number of staff members wanted a regular meeting at which change is an indentified part of the agenda. The consultation and education sessions, for instance, might be used as a vehicle for this. The consultant emphasized the need for a way of identifying needs and procedures for evaluating current and planned programs.

Staff were divided about whether a vehicle for implementing change, or even discussing it, exists in the center. The consultant noted this ambivalence about the communication system and suggested that sharing of ideas might have significance beyond the topic of change.

The consultant pointed out that one of the services, most likely inpatient, might be a profit-making unit for the medical center. Since the center does not have its own accounting system, they had no way of knowing of this possibility. In his follow-up letter, the consultant reinforced the idea that the director investigate a means of getting regular information about the cost of services, especially inpatient service. This information could be important in program planning and as a power base for dealing with the hospital and county on budgets. This information could give the center the base it needs to stress the fact that it is indeed an asset to the hospital.

Visits by Center Staff

Five centers were selected for visits. The center director and the director of inpatient services visited two centers located in the same NIMH region. Another senior staff member visited three mental health centers in an adjacent region.

Directors' Visits. At the first center, the two directors observed inpatient and day treatment services. These programs were aimed at a relatively well-motivated middle-class population. The director of inpatient services at Dove Center indicated that some components of the program could be useful, especially the formation of separate wards for the more motivated inpatients and the highly disturbed inpatients.

A regular staff meeting was held after the visit. Staff reaction was favorable, but lack of funds made it impossible to implement any program.

The second visit was to a mental health center located in a suburban area providing services for an entire county. Both visitors were impressed with this center's total program, but the director noted that the two centers' social, legal, and political environments were so dissimilar that he could not recommend any of the components of the program.

Nurse Visits. A clinical nurse specialist, who is in charge of the jail program at Dove Center, visited three other mental health centers. One visit was only a tour of the building facilities and a general orientation about the center's programs. There was no direct observation of program activities. Many aspects of the program did not seem useful because of the center's traditional approaches to the treatment of clients.

The site visitor had quite a different reaction to the two other centers. Both of them impressed her, one because of the different philosophies of patient care that existed, the other because of the staff, who were creative and willing to share their experiences.

Two aspects of one center, located at a state hospital, seemed useful: a team intake approach and the training of community people as outreach workers. At the other center, the program consisted of a decentralized mental health center which had satellite clinics throughout the county. The site visitor thought that Dove Center could assign mental health workers existing community agencies to increase community contact. The number of staff required to implement this aspect of the program was the main limitation. The site visitor recommended that the philosophy of approaching the community be applied to Dove Center's community projects.

A regular staff meeting was held following visits to these centers. Staff reaction was mild; the site visitor felt the staff had difficulty in applying useful components from other centers. The site visitor reported that a special meeting which allowed a longer, more specific discussion on the components of these programs, might have generated more interest.

ERRIDGE CENTER

Background

Erridge Center serves a middle class suburban area in the Rocky Mountain states. The center itself is located in a well-established small city of nearly 50,000, at a distance of about 30 miles outside the metropolis. In recent years, the city has been surrounded by rapidly growing suburban tracts, to the point where it is part of the area's urban sprawl. A large part of the catchment population of about 131,000 lives in these new developments.

The center opened as a source of comprehensive services in 1967. In 1971, it underwent a major reorganization, and the present leadership was brought in. Its annual budget is in the range of $250,000-$500,000, which supports 35 full time equivalent personnel. The center is governed by a board of 12. Six of these are appointed by the county commissioners, and six are elected by the community.

Although the region is growing fast, the population of the catchment area is homogeneous. It includes only a small poverty pocket and has virtually no minorities. The average family income is $12,000. As would be expected from this income level, the area is able to support many private practitioners. The population's socio-economic status is reflected in the kinds of problems its residents have. Currently, the center admits about 1,500 patients a year.

The largest pressure the center faces is from the rapid growth of the area. The center can anticipate continued population increases and must decide how to organize its staff and programs to deal with the new residents.

Services

The center indicates that it provides a conventional group of services: inpatient, outpatient, partial hospitalization, emergency, consultation and education, rehabilitation, precare and aftercare, and children's problems. In practice, some of these services take low priority. Most inpatients, for example, are referred to a large mental health hospital in the metropolis. Children's and old people's problems are emphasized less than adults'.

The center uses a private practice clinical model, with one-to-one client-therapist consultations. The staff has made efforts to reduce treatment time, and over the last few years this has declined from 18 months to three. At any one time, about 300 to 400 patients are being seen. In terms of the size of the catchment area, this is not an especially large load. Despite the staff's fears of being caught umprepared for expansion, the center is so far dealing with a very small segment of the community.

In general, the staff leans toward a psychological rather than a psychiatric approach. Two consequences of this approach are emphases on behavior modification and empiricism and measurement. As part of their enthusiasm for behavior modification, the center has begun to sponsor annual conferences on the subject. The two that have been held so far have been very well attended.

As evidence of the center's concern for quantification, the center has developed a systems approach. Each of its goals is broken down into subgoals and objectives, and the success of each objective is indicated in mathematical terms. The center is concerned with evaluating its programs through user questionnaires. They note that 88 percent of users contacted felt they received satisfactory service; further, 96 percent would return to the center if necessary.

Staff and Organization

The staff includes one full-time psychiatrist, six psychologists, eight mental health workers, 12 social workers, and clerical help. The top officials include an executive director, a medical director, a research director, and a fiscal director. The rest of the staff are divided into four teams, each of which covers and comes to know a certain section of the catchment area. Each team includes members with a variety of skills, and consultation across teams occurs as needed. Despite the preference for behavior modification, the center does use multiple modalities of treatment.

The staff are mixed in terms of age and background, but they share a dedication to the center and its work. They are seven-day-a-week workers, and for several of them, especially those who are single, the center seems to be their whole life. As part of their dedication, the staff members are enthusiastic about and committed to change. Center directors believe that most staff (70-90 percent) are willing to innovate, develop new professional skills, and take on new responsibilities. Informal staff discussions about new ideas are frequent. In group meetings, it is apparent that the staff is aware of effective programs elsewhere. They draw few distinctions between community workers and professional staffs on the question of expertise; rather, they apparently regard themselves as generalists.

In line with staff members' extreme interest in their work, the staff engages in constant self-analysis. The systems approach allows for and encourages feedback. As part of this approach, the center has set up a plan in which each staff member (in consultation with his supervisor) sets up quantifiable goals for himself. His promotions and raises depend on the degree to which he meets or exceeds those goals. Staff members are enthusiastic about this plan.

Decisions at this center used to be more democratic than at present; the center has pulled back from this approach as it has grown. In terms of hierarchy, there is an executive council, an administrative core group, and the staff. The executive council has chief decision-making power. It encourages staff input, and it strives for consensus rather than using a veto. Still, the council displays a certain "relentlessness," to use the consultant's word, in pushing what it wants. The staff accepts this procedure. Within the teams, communication is open and egalitarian, but the staff realizes that some decisions above the team level will not be made democratically. As the center expands, this tendency may increase.

Current Situation

As noted above, the center's most pressing problem is organizing staff and developing programs to meet the burgeoning population in their area. This pressure is felt strongly. The staff feels they have only a little time to prepare for the influx. They use the systems model, with its development of objectives and quantification of results, as a means of keeping on top of the problem of organization.

Nevertheless, it is unclear whether the center has thought out its long range plans or made much provision for comments and suggestions from outside sources. The center has not done a needs assessment survey. As a staff member pointed out, new cases are put into existing programs, rather than the center developing new programs to fit cases.

The center's priorities for new programs are also unclear, although alcoholism and children's programs are mentioned as possibilities. The center's concerns, according to the director, are center organization and administration, program planning, program evaluation, promotion and funding, and community consultation and education. With the exception of the last, these are all administrative rather than program concerns. They indicate a concern for organization rather than content, which seems typical of this center.

Consultant at the Center

The consultant was a psychiatrist who had founded a community mental health center in a West Coast city. The center brought together services from a variety of federal agencies, and it had drastically reduced the number of inpatients in local hospitals.

The consultant's style was businesslike yet informal. He preferred to speak anecdotally rather than lecture. Rather than speaking about the change process, he referred to developments in the region and nation. He saw himself as a source of information the center could use.

In terms of the center's programs, this consultant was concerned with upgrading the treatment of patients and reaching out to new patients, and also working with other agencies. (The center has been working with police on ways to treat alcoholism.)

In terms of change, he stressed that program development is a task in itself, not just something done in spare time.

Visits by Center Staff

Given the staff's interest in a behaviorally-oriented systems approach to both administration and treatment, their decision to visit another center which makes use of a similar approach was appropriate and unsurprising. Two of the directors made the trip to a center in the Southeast. They found that some aspects of the program might be useful in their existing program; in particular, these were specific applications of treatment goal systems to inpatient and day treatment program. But the executive director noted, "Ours is in many ways a stronger program. Visiting another very good center simply gave a sense of the correctness of our own efforts."

When the two directors returned home, they described their impressions in a regular staff meeting and a special executive staff meeting. The staff was enthusiastic, and given the chance to make a follow-up visit, six of them took the opportunity. (This provision for staff participation in travel is an example of the non-authoritarian practice of the group.) These staff members had a reaction similar to the directors'. They were cautious about grafting large parts of another program onto their own before making sure they would really fit. However, the center has already implemented some parts of the program, and they are considering bringing a visitor from the Southeast center for further discussion. The visits, therefore, were useful.

FLYNN CENTER

Background

This publicly funded mental health center, located in the inner city of a southeastern urban area, has been open since September 1970. Its staff of 55 full-time personnel operates on an annual budget of nearly one million dollars, serving a catchment area that has recently more than doubled in population [illegible] nearly 400,000 persons.

The center is located in a large building only two years old; already, however, its space is beginning to be inadequate. Its clean, neat appearance almost approaches the point of sterility. Located in an attractive wooded area with ample parking available, it is close to an also-new mental retardation facility, as well as the county Human Resources Agency, and borders the site of an inpatient/cottage complex that will be built with proceeds from a two million dollar bond issue that was passed in 1972. Physically, the center's biggest drawback is that its location is inconvenient for patients dependent on public transporation; however, almost anywhere else that it might have been located, other than the downtown area, would be equally inaccessible.

The center, even though only three years old, has a near-chaotic history of rapid growth and development, with more anticipated in the future. The staff has experienced a great deal of frustration in dealing with the rapid changes, and as a result, they now approach the change process with apathy rather than enthusiasm.

In addition, the center evolved from independent adult and children's agencies. These two divisions still appear to function with almost no communication between them, primarily because of a difference in approaches.

When the center received a staffing grant in the early 1970's, the size of the staff tripled overnight, and at the same time there was a dramatic change in patient population from an upper middle class clientele to one that is 70 percent unemployed and 30 percent Black.

The center, as stated earlier, is an arm of county government, and thus operates on public funds. The center's director seems to be very aware of the importance of the role of politics in obtaining funding, and this is one of his main areas of expertise. His "social research assistant" recently managed the passage of a two million dollar bond issue for the new in-patient unit to be built on the grounds. If this is an indication of the public's support of the center, it can be assumed that it will have a strong financial position in at least the immediate future.

Services

This center's staff couldn't describe their philosophy, so the consultant attempted to describe it for them, based on their behavior rather than their words: He saw it as a philosophy of severe traditional treatment—but with the added facet of the staff seeing themselves as trainers in almost an academic kind of way. The trainer function, the consultant noted, borders on some very progressive community education ideas. Much of the training this particular center is doing is in-house — dealing with students, interns, perhaps even residents — but some of it definitely moves into community education, such as its programs for clergy and teachers.

The staff did indicate they wished to move from a medical model to some other kind of model, and although a "social model" was mentioned, what they really hoped to achieve was rather unclear. So although its philosophy seems to be changing direction, the center as yet had not defined its working mode.

The center offers both group and individual therapy programs. Some of the staff are far more "old school" than others, especially in the adult section. The children's section does a lot of family counseling, working with parents of the children in the program. The staff of the Children's Division appears more amenable to change than do most of the Adult Division staff.

The center itself provides outpatient, partial hospitalization, and emergency care services; it has an active consultation and education program; facilities for diagnostic services, precare, and aftercare; and a children's division. Inpatient emergencies are referred to the emergency room of a local hospital, where a psychiatrist is on call; children who require inpatient, partial hospitalization, or special diagnostic services are referred to a local private children's center. Services for the mentally retarded are provided by the center, but programs for alcoholism and drug addiction are subcontracted out.

Staff and Organization

The director of this center can be hired or fired by the county, but political influence stops with him. The medical division heads and other staff are civil service employees.

The present center director operates in an autocratic fashion, but not necessarily because he believes that is the best way. The consultant found him to be very open to the group democratic process, if only the group would make decisions and take action on those decisions. The director is afraid, however, of indecision and inaction, and has found he must step in to keep things moving.

Although the Adult Division is headed by a triad of staff members, and the Children's Division nominally by a physician and functionally by a Ph.D. clinical psychologist, the real movers and shakers in this organization are the "hustlers," the staff members who conceive of an idea or plan or project, then "hustle" it up to the top, where they gain approval (or disapproval). The "hustle system" in fact, appears to be how the center as a whole functions, even in such areas as obtaining funding or planning future directions. Several staff members have assumed a portion of the power held by the director by virtue of being close to it (him) and just grabbing hold--they "grab" the power rather than letting it go unused.

A triad, as mentioned earlier, presides over the Adult Division. Apparently even when headed by one person, the division didn't have much authority; now members of the triad feel they are still powerless because management does not back up the authority of the unit director. What emerges is a portrait of a staff, some of whom are reaching out for an authoritative structure, and others who, though they do not want such authority, can see that what they have isn't working either. One complaint is that the administrator gives staff little feedback. In this organization, it seems, "no" doesn't come across very clearly, and if someone wants to get something done, he has to battle a great deal of passive, rather than active, resistance.

In both divisions there is a great deal of intragroup tension. In the Children's Division it may have resulted from a long leaderless state, with no one taking the initiative to appoint or elect a leader. In the Adult Division it seems attributable, at least in part, to the appointment of the triad by the administrator to relieve a leaderless state.

In addition, the Children's Division is characterized by a management-staff conflict, and the Adult Division by an old guard-new guard conflict.

Intergroup tension also is evidenced, stemming perhaps from the former separation by geographic distance. Even their present physical proximity doesn't seem to be closing the gap, however. Their present differences seem to spring from their differing treatment approaches.

Obviously, communication among staff at all levels is an area that could be improved at this center. One staff person mentioned that even when given the opportunity to air problems or discuss situations in group meetings, most people would rather "cry behind closed doors."

In spite of these organizational and communication problems, the staff seemed committed to their programs and their personal goals in their work. Specifically, their programs in community education are quite progressive, and opportunity for those who wish to carry the ball and "hustle" their own programs does exist.

Current Situation

A great amount of pressure has been exerted on this center by its rapid and large growth—it is, in effect, now serving two catchment areas with the staff intended to serve one. In addition, the present staff doubled or tripled almost overnight when they received a federal staffing grant. When the new 80-bed inpatient unit opens even more staff problems may result, since they will be working with state personnel in that facility.

The staff mentioned the following programs which they felt would meet the most pressing community needs: (1) a 24-hour emergency telephone service and adequate emergency care; (2) some means of providing transportation to the center for needy clients; (3) satellite centers in distant parts of the catchment area; (4) halfway houses; (5) more intensive, short-term treatment for geriatric patients; (6) walk-in service; (7) more communication and cooperation with the city's other social service agencies; and (8) more of a community health approach in the children's program.

Consultant at the Center

It was perhaps especially fitting that the consultant who visited this center is particularly enthusiastic about group dynamics, since this organization seemed to be so weak in that area. By the end of the visit, however, the staff seemed committed as a group to making good use of the opportunity to visit other centers.

The consultant reassured the staff that the process they used to decide how to handle the $500 decision didn't really matter—that they should do it the way they knew best. If that happened to be using the "hustle system," and that got the job done, that was what counted. It would be nice to have an ideal group situation, he said, but the decision should be made on an operational level. Privately, he voiced some concern that if the staff put all their energies into focusing on the process, they might never get around to making a decision.

Finally, however, the staff determined to request of management a structure in which group process could work effectively to deal with the site visit decision. Some commitment, as well, was made to seek the same or similar structuring for the more pervasive problem of decision-making.

Visits by Center Staff

At the time of the consultant's visit to Flynn, no decision had been made about the site to be visited—or even the type of program they might like to look at. The AIR visitor noted that "it appears that the decision will be determined primarily by the personal interests of the most effective hustlers in the groups." Apparently the staff did at least attempt, however, to use the group process in determining the sites and visitors, so this might be an indication of their willingness to try change.

As it turned out, four staff members from the Children's Division visited two centers which have active school consultation programs, an area in which

Flynn has done some work but would like to expand.

This first center has a school liaison worker. Two members of the Children's Division staff indicated a desire to visit her to discuss how the program began, problems she encountered, and suggestions she had to offer. They believed they could implement a similar program in the near future.

After their visit, they felt the same program might not be directly transferable to their own center, but did believe one aspect of it — recruiting a new social worker position out of the school system — might help solve their problem.

Eight staff members attended the regular staff meeting at which a summary of the visit was presented, and reaction appeared to be favorable. One of the visitors also noted, "The opportunity to put my own center's operations into perspective by contrasting it with the other center was invaluable."

The two persons who made this trip are members of the adolescent team of the Children's Division. Their goal for the coming year was "to develop a consultation program with the school system that would possibly include the school contracting for certain direct services from us." The center they visited provides, on a contract basis, leadership for groups in the schools which are designed to help children improve interpersonal skills and school adjustment.

The visitors felt that aspects of this program might be adapted for their own center, but because their school system has a cadre of school psychologists and social workers, the consultation probably would not have to be as comprehensive as in the site visited. However, when the summary of the visit was presented in a staff meeting, it appeared that most of the staff were not eager to enter the school setting. There was a feeling that school consultation is necessary, but disagreement about how to accomplish this goal. About a third of the staff seem interested in adopting a similar program, however.

The two staff members who visited this center are working on a proposal to implement some of the ideas they observed at their own center. Both were enthusiastic about the visit, and felt that "AIR's plan was an excellent idea."

Responses on the final questionnaire sent to key personnel indicated that administrative staff and Children's Division staff members believed the site visits to be a useful tool; however, members of the staff of the Adult Division indicated practically no awareness of the site visits, who went, how that was decided, or what was learned.

GRANGER CENTER

Background

Granger Mental Health Center lies in the Rocky Mountain region in a town of 13,000. The center serves a five-county catchment area comprising a population of 75,000. This rural center has been in existence since September 1970, and is jointly funded by the five catchment counties, the state, and the federal government. The annual budget runs between $250,000- $500,000, which supports a full-time equivalent staff of 15 people. According to the information received, the general socio-economic status of the center's patients is low, but this is not reflected in the unusual "wealth" of the center.

Currently the center is undergoing a process of decentralization, which will include expansion. The center's structure will be more complex, and time will be consumed in adjusting to the new procedures. This seems to be the only problem or pressure the center will have to face. The center has an excellent staff and the problems of readjustment seem to be a minimal task. Center concerns, as told by the center director, include community consultation and out-patient treatment, staff development and program education, and evaluation.

Services

There is no special emphasis placed on any one program because the center is striving to develop complete comprehensive services for its patients. Granger feels that due to the nature of decentralization, the five essential services which comprise a comprehensive center are not applicable in its present situation. The center presently relies heavily on inpatient and outpatient consultation and education, with a very limited consideration for crisis and emergency service. If any service is stressed, it is the inpatient service, which is used for alcoholism because of the high number of alcoholics in the area.

The center responds to the responsibility to reach out into the community. The center has attempted to make contact in the public school system, church organizations, family organizations, and other community services. These attempts resulted in the formulation of a community television program, community family therapy and teen groups, consultation groups in family, consultation in sex education, and children's services. There is a good working relationship with the local clergy and nursing homes. Besides cooperation from the community, the center has received assistance from judges and other local public officials. Also there is a unique relationship between the center and the state hospital, located at the center. The relationship these two share is unusual because they are both working toward one common goal—health care. Both staffs are dedicated and share no conflicts even though they are separate institutions. The "marriage" between these two organizations enhances the functioning of the whole center.

Staff and Organization

There is a shared responsibility between programs and administration in the center and hospital. The actual key staff is the center's director and his clinical director. Both are very progressive and only hire staff who share their points of view.

The 15 full time equivalent staff under these two are young—in their middle thirties—and progressive. They received their "roots" from the community, an important factor, which makes them more creative in assessing the needs of the community. Only the psychiatrists at the center are "older," but this does not hamper their ability to interrelate with the rest of the staff.

The staff is well informed about mental health practices and programs, even though there is very little or no input from the few neighboring centers (there are fewer than 12 mental health centers in six of the Rocky Mountain states).

The center director chooses only staff members who will work well with him. He chooses his staff to work with him and not under him, making this a very significant factor in the relationship between higher and lower staff. He is democratic in delegating his authority and he encourages his staff through his good leadership to search for new ideas and to be patient-oriented in their work. These elements account for the low turnover rate at the center.

Communication among staff is good. Regular weekly staff meetings are held with open discussions on patients, and new treatment ideas are brought up during the meetings after the regular agenda is cleared. The morale is high and the staff is positive about their work.

Current Situation

The center is undergoing decentralization. Staff members take a healthy attitude toward this change in general.

The main pressure facing the center now is the integration of the organization into a new system. Since staff contact with the community is close and amicable, they do not receive any pressure from the community concerning this change.

Consultant at the Center

The consultant was well received by the center, but because of its progressive nature, his presence did not stimulate any new action. He felt very comfortable with the center, and in fact he received more input from the center than he gave.

His particular approach to situations brings out the "good side" of the staff—he would much rather stimulate discussion than control it. There were no problems with communication and no one became defensive because of the consultant's questions. The consultant made a point to see that all members participated in discussion by either directing the conversation toward the quiet member or by asking questions "forcing" him to contribute. If he sensed the defense barriers going up, especially from administrators, he toned the discussion to such a level that the "uptightness" slowly dissipated.

Visits by Center Staff

Site Visit 1. This particular center is a typical urban mental health center, providing the usual range of services. An unusual feature of this center is that rather than hiring a larger staff, it involves the community as much as possible in rehabilitation.

Impressions about the visit were relayed to the staff at their regular meeting. Not much interest was generated by staff. They felt the program visited would not be useful at all at their center.

Site Visit 2. Another center visited contained some workable programs that could benefit Granger Center. Of particular interest was a day-care program and an educational program for law enforcement officers. The visitor was also impressed by the excellent working relationships and services provided to the community even though a minimal amount of time was spent planning in staff meetings.

Much more interest was displayed when the site visitor reported his experiences at the staff meeting after his return. The visit was meaningful and it had a definite impact on the center staff.

HELSPAN CENTER

Background

Helspan is a large private mental health and mental retardation center located in the inner city area of a large urban area in the Northeast. The catchment area population is approximately 130,000 and is 14 percent black. A large segment of the white population is Italian-American. Since its opening in 1965, Helspan has operated as a direct part of the services offered by a large general hospital. The socio-economic status of the clients served is low, and fees for services are based on clients' ability to pay.

The pressures and needs of the community are typical of low income inner city populations. Inadequate housing and a high unemployment rate were two of the problems pointed out by the staff at Helspan. Whether or not the center sees itself as responsible for providing services for these kinds of problems or seeing that they are delivered had not been resolved at the end of the consultant's visit.

One unique feature at the center was the planning for alternative sources of funding prior to the elimination of federal support. The center had applied for funds through the local chamber of commerce and alternative federal sources such as new program funds from the health maintenance organizations (HMO). According to one staff member, "the federal funding cut is the kind of stimulation for change that a seven-year-old center like this needs." Preparation for other major program changes such as a management information system, program evaluation, community relations committee, in addition to the funding program, contribute to the uniqueness of this center.

Services

Helspan currently operates along the lines of the traditional medical model. It provides comprehensive services based on a mental illness approach rather than a mental health approach.

Because of the MR component at this center, the law mandates that the center provide services in the areas of housing, vocational guidance, and placement for its clients. The MR staff strongly supports the philosophy that the center provide these reality services to all clients being served. The other staff members would prefer to continue providing traditional direct services and not assume responsibility for solving reality problems. This conflict in philosophy was a major topic of discussion during the consultant's visit. There has been pressure by the community for greater community involvement and preventive services, indicating the need to move toward a mental health model if the center is sincere in evaluating its role in the community. Many staff members expressed concern about the center's role in the community.

Since 1969, the center has had a community relations committee, composed of representatives of the main services at Helspan and representatives from other community service agencies. Although the county imposed this participation by the community, the approach has been effective in sharing of information and increasing the participants' awareness of community attitudes and needs.

Helspan stresses direct services. Services for adults include an outpatient clinic providing emergency care, individual and group therapy, chemotherapy, and a short-term inpatient unit. The outpatient clinic is set up to provide continuity of care for all patients. Services for children are based on a consultation-prevention-intervention model and include a developmental disabilities program, learning center, outpatient services, and diagnosis and evaluation. Other services include community consultation and education, and a research and evaluation unit designed to keep the center's services up to date with the community's needs. Other services available to residents of this catchment area include a diagnostic and rehabilitation center for alcohol and drug abuse, and a halfway house offering aftercare and rehabilitation services.

Staff and Organization

The organization at Helspan is hierarchical. The director has the ultimate decision-making authority. Two associate directors and the directors of the main six services make up the remaining key administrative staff. Although administrative staff meetings do not occur on a regularly scheduled basis, the discussions during the consultants' visit were open and informal and provided a way for sharing information about the center's programs.

There are more than 100 professional staff employed at the center. An atypical feature of this center was the concern of professional staff at all levels for quality care. Key staff believed the commitment to quality care coincided with the employment of highly trained professionals. This criterion resulted in the employment of very few paraprofessionals.

Interviews with senior staff members indicated a high degree of communication and positive interaction among staff members at all levels. A system providing opportunity for ideas to go from lower level staff to upper level staff existed. However, opinions expressed by middle management staff indicated that the system did not always work, particularly when communication from upper level staff to lower level staff was involved.

Middle management staff expressed a desire for more decision-making authority or even some indication that their opinions had been heard by upper level staff. The clinical staff showed a great degree of awareness of the pressures and frustrations of administrators and understood that they are responsible for clinical changes. They also recognized the need for increased communcation to assist them in overcoming their own pressures.

Current Situation

During the consultant's visit, individual meetings were held with the center director and the two associate directors. The consultant used these meetings as sounding boards for staff members to share their views about the current needs and pressures confronting their center. This top management group considered a management information system as their priority need. The system would assess what they are doing, who they should be treating and how to make program planning decisions.

A second major need expressed by this level of staff was a greater effort to promote community participation. During a small group meeting and individual meetings with key staff members, the need for the center to identify and clarify its role in the community was considered the current major concern. Middle level staff especially felt they should be doing more in the community and were frustrated about effecting change since top management did not recognize this as a great need. Top management was convinced the medical model was justifiable. Middle level staff recognized the need for an improved communication system to and from all levels of staff to lessen the existing differences about major needs and objectives of the center.

Consultant at the Center

Meetings had been arranged for the entire two-day visit. The morning of the first day was spent with the director and the two associate directors. That afternoon a group meeting was held with key administrative staff. The morning of the second day consisted of individual meetings with key staff and attendance at court commitment proceedings held at the center. The afternoon included a feedback meeting with key staff and a final interview with the director.

During the introductory meeting with the director and associate directors, the center's future funding sources, organizational structure, and major problems were discussed. An associate director pointed out that major needs were in the area of community participation and a management information system. It became quite clear during the afternoon group meeting attended by the directors of services (middle management) that the two levels had not identified the same needs. The directors of services identified defining the scope of their mental health services as the priority need. Whether or not the center should provide services in the areas of housing, vocational guidance and placement, and other reality problems created much debate at this session. Most staff members openly expressed their feelings regarding the mental illness model vs. the mental health model.

Discussion of the change process, stimulated by the consultant's questioning approach, was another topic covered during the first day group meeting. The staff pointed out that change resulted from three mandates: legislative, community and professional opinions, and perceptions of need. Staff awareness of the realities of the change process was brought out even more during individual interviews with staff members.

Throughout most of the first day the consultant's role was essentially that of listener. During the debate regarding the mental illness model vs. the mental health model, the consultant offered an alternative for Helspan. He suggested the center assume an advocacy role for reality problems of the clients. But staff members who supported the mental illness model were not willing to assume even that degree of responsibility.

The consultant's style of listening continued through the individual meetings with key staff. The questions he did ask focused on the change process. These individual interviews provided a more detailed look into the staff's opinions regarding change and the center's major needs. One staff member pointed out a fourth factor affecting change at Helspan: the program directors' resistance to change because the pressure to change has come from the outside, i.e., political, financial, or legislative pressure. Also, during these interviews staff expressed the need for more communication so that they might have meaningful input regarding major policy changes.

The consultant's feedback session occurred on the afternoon of the second day. The objectives of this session were to communicate to the staff how the consultant perceived the staff as perceiving themselves, to outline what had been observed, and if requested, make suggestions. These objectives were communicated to the staff in the consultant's introductory statement. The observations were reported, not as an evaluative or critical statement, but as an attempt to relay information.

The consultant began by presenting the atypical aspects of the center: breadth and depth of performing services, and the staff's awareness and concern for quality care. The consultant also applauded other favorable aspects of their program, especially the volunteer program.

He then relayed some observations of concern which he had noted. One area of concern, found in most centers, involved the system of communication among the different levels of staff. He stressed the importance of an ongoing two-way communication system. And because communication among all staff appeared to be encouraged, the failure of the system in actuality indicates a lack of concern by those who could take positive action.

The consultant then recalled the major need of the center as reported earlier by staff members: the need to look beyond the traditional medical model. He agreed that this was a major need in terms of the future of all community mental health centers.

Staff responded to these observations by asking the consultant for suggestions on how to solve these problems. The consultant offered some alternatives, such as retreats to discuss concerns in-depth and putting the topic of change on the agenda at staff meetings.

The effectiveness of this consultant's style at this center is indicated by the response of a staff member at the conclusion of the feedback session: "This is the first time a consultant actually did something." The consultant's technique of listening, observing, questioning, and summarizing observations has been effective in other types of community mental health center settings. It provides stimulus for discussion in which all levels of staff can participate.

Visits by Center Staff

During the consultant's visit to the center, it was not clear whether the site visit would match the center's current needs. It was clear that they wanted to observe a center as a whole rather than any particular program within a center. The consultant offered suggestions abour centers to visit, but the site selected was a center that senior staff and director already knew had a reputable program, particularly in the area of children's services. At the final meeting with top management staff, an interest was expressed in the management information system of the center that was finally selected for the site visit.

The director made the final decision regarding the selection of the site visited. Senior staff members and the director of Helspan Center had heard the director of the selected center speak at a statewide mental health meeting and were impressed with the information exchanged at the meeting. Five senior staff members and the director made the visit to this public mental health center located in an adjacent NIMH region.

The visit focused on children's services, especially the Child Development Center, which offers treatment of developmental and emotional difficulties for children under the age of five. One staff member observed aspects of the consultation and education program and the management information system.

The direct services offered at the center were the most useful aspects of the program. These included services to pre-school age children and the disaster and crisis teams. Two staff members reported that aspects of the consultation and education program would be applicable to their center, particularly the emphasis placed on cooperating with other community agencies.

All staff reported that certain aspects of the center's program would not be useful at their center. The traditional treatment philosophy, involving highly qualified personnel (M.D.s) was too expensive and exclusive for the lower class urban area of Helspan. In addition, they belived this approach inhibited the use of individual resources of other staff members. Generally, the unsuitable aspects resulted from the differences between the two centers in the types of population served (middle class vs. lower class) and geographical setting (suburban vs. urban).

The visitors reported their findings and reactions at a regular staff meeting attended by 15 staff members. The staff reaction to the program was generally positive. Some staff expressed envy of the resources and facilities of the center visited compared with the limitations of their urban center.

Staff reaction to implementing a program similar to the one visited was mixed, but the majority of site visitors did not favor implementation because of essential differences in treatment philosophy, population served, and physical surroundings.

Reactions by the site visitors to visiting another program were positive and comments stressed the opportunity to observe and compare another program as a valuable experience. Replicating all or part of the program observed was not a goal of the visit.

INSTEP CENTER

Background

Instep opened in September 1971, and is attached to a general hospital. It serves a rural area in the Southeast which consists of six counties. Its staff numbers 32, and its annual budget is in the range of $250,000-$500,000. The catchment area has about 72,000 people; the population served by the center is low income.

At the time of the consultant's visit, the center had been open slightly more than a year. In its first six months of operation, it had served more than 700 clients. This had taxed its overloaded staff and facilities. As a result of this condition, the center director was frank about not wanting to publicize the center's services further. The consultant noted that although many center directors feel that way, they rarely admit it.

Little information on funding was gathered. But the director noted that the state gives 98 percent of its mental health funds to state hospitals, which suggests that the center funds must come from federal and local governments. The hospital to which this center is attached views the center as a stepchild, a not uncommon relationship between the health and mental health professions. The tenuousness of mental health funding may accentuate this relationship and suggest why the hospital is rumored to be casting covetous eyes on the center space.

Services

Based perhaps on the relationship with the hospital and also on the background of its director, who is a psychiatrist, the center uses a medical model of treatment. The clear priority is dealing with the sickest patients, and therefore the focus is on inpatients; an objective is to reduce the number of patients in the state hospital. The big problem in terms of treatment is aftercare. At present, the staff is not able to deal with its own discharged inpatients.

The staff as a whole apparently does not share a consistent philosophy. Their approach is mixed, and the general goals of the center are fuzzy. However, it may be moving towards the idea of a therapeutic community. In the past, it has used electro-convulsive shock more often than the average community mental health center, and it has also relied on psychoactive drugs for treating its inpatients.

The center has some outreach satellite programs. Some of the staff are active and interested in community consultation. One new program has been started since the center opened: a comprehensive alcoholism program with a halfway house.

Staff and Organization

The center director reports to the executive director of the hospital. (The hospital's board of trustees also oversees the mental health center.) The director is a large man between 55 and 60 who seems like a country doctor, according to the consultant, and appears very open. But the staff see him differently. During the visit, it became clear that the staff views him as an arbitrary dictator who makes decisions at whim and changes them at whim. This capriciousness, which they feel extends to their jobs, has damaged staff morale to the point where it, along with the heavy caseload burden, is the center's major problem.

An example of the size of the problem had occurred a few months before the visit. The staff, including the director, were undergoing group therapy as part of staff development. One staff member challenged the director strongly on a particular policy, and the director fired him on the spot. This incident cowed the rest of the staff, who now find it difficult to express any kind of dissent.

Staff members individually may be interested in trying new programs--the consultant and AIR observer rated their willingness as "considerable"--but staff morale makes it hard to work together, and the heavy caseload means they have little time to innovate.

The staff themselves have a variety of backgrounds. A psychiatrist is director of clinical services. The staff also includes psychologists, social workers, and a registered nurse. A clinical chaplain coordinates the alcoholism program. No information was obtained on staff turnover, but between the visit to the center and the center's visit to another program, two staff members resigned. One was the nurse, who had been outspokenly critical of the center's director.

The director is very much in charge of the center. He makes decisions, and he changes decisions that have been made. His changes in direction and goals are made without consulting the staff, "at whim" in the words of the nurse. This pattern has also made it difficult for the staff to work with confidence.

Current Situation

Like many centers, this center has both a critical internal and a critical external problem. The internal one has already been mentioned: the effect on the staff of the director's apparently arbitrary and dictatorial style. One reason for his being that way is his skepticism over the future of the center and the center concept. Often the director's decisions are the result of some political problem, but he does not share these dilemmas with his staff. As a result, all they see--and are sometimes bewildered by--are the end products. The staff in turn feels unable to speak freely to the director about the center's policies or their own frustration.

The external problem concerns funding. During the visit, the center received word of some funding cuts. Money the center had planned to use to start an alcoholism program was slashed to zero. The staff was shocked at this, not only because the alcoholism program had not really gotten off the ground but because the center has had a habit of counting on money before it had actually been received. The danger of doing this suddenly became clear to them.

The staff is having to make the same realization as other centers have come to: that continued funding, regardless of its source, depends on a salable, cost effective product. The center has not yet been able to demonstrate it has this.

Consultant at the Center

The consultant, a center director from the South, combines a folksy exterior with an incisive mind. His manner and his understanding of group process enabled him to get at the problems within the staff, even though the director had (it was learned) explicitly warned the staff not to tell the consultant anything.

The visit itself began with a series of individual meetings with the director, the psychiatrist, a social worker, the clinical chaplain, and the nurse. The director was reassured about the purpose of the visit. The individual meetings were helpful for bringing out a feeling of something wrong at the center. feeling seemed to be an apprehension about speaking out, in particular of not agreeing with the director.

At the first group meeting, attended by about eight staff, the sense of stress was clear, although the reason for the stress was still undefined. The director sat in. The meeting began with the group trying to decide how to use the $500 allowance. Various site suggestions were made and discussed. The discussion exemplified how not to use the change process: instead of discussing the center's priorities and what centers they could learn from, they talked about where to go and how to get there. The consultant tried to get the group to decide their priorities. Finally, under the consultant's probing, the group came up with a list of about ten areas of interest. In trying to narrow down the list, the staff still stuck to their own pet areas. In further discussion, the staff noted how much trouble they were having making decisions. As the nurse said, this was not the first example of the problem.

As discussion continued, the director pointed out that it didn't make any difference which site was visited, since the center could learn from any mental health center. The consultant noted that this was a legitimate strategy: choosing a center fairly much at random and then deciding what to learn from it. Another staff member suggested augmenting the $500 with center funds for a trip to a distant center or conference. Finally, most of the staff agreed to look at a total program in a comparable area. The consultant mentioned that they might learn as much from a center that is not as well put together as from an ideal one. The meeting ended with one staff member being assigned to look up through the Source Book of Programs and come up with some possible programs.

Before the second day's group meeting, the consultant and the AIR observer met with the director. They discussed the staff's problems with the director, particularly their inability to speak freely with them. They also pointed out the director's tendency to hide his problems from the staff. The mood of the meeting was serious; the director's attitude was somber.

The director did not attend the group meeting. The first part of this was spent in making decisions about the site visit. Some programs were suggested, and the group agreed to make a selection by the end of the month. Teams of three would go to each of three centers. The subject of funding came up--in particular the effect of the funding cut on the alcoholism program. The staff admitted that their future programs cannot count on money that they do not have.

It was in the last hour that the staff really got into the source of so much of their trouble: the relationship with the director. The consultant began by reporting what he had told the director at their meeting. This led to an intensely emotional discussion of the staff's fear of being fired. The discussion was not all one-sided against the director. Some staff noted his potential for openness; they had seen him act differently away from work. Others were wary of the topic altogether; they were unsure whether to talk about it and how to talk about it. Basically, the staff like him personally but are afraid to approach him. They remember his capriciousness and arbitrary assertions of power. There are specific resentments--the director conducts his private practice during working hours--as well as complaints about management style.

The group recognized that the director might not realize the way he appears to them; they saw that he might also be in a bind about them. This helped the consultant get them out of their own selves to look at the total situation. They began to see that they have strength as a group, since he can't fire them all. Some staff made impassioned pleas for being open with the director and bringing the problem to his attention. Others still feared this. By the end of the meeting the staff had resolved to work together towards better relations with the director. They planned to meet as a group, but without the director, with a psychologist who consults with the center. They would try to work out their problem there.

Visits by Center Staff

Although the staff originally planned to send teams to three centers, only one visit was actually made. Two of the three centers were in Kentucky, and could be covered on one trip. But when two staff members resigned, the trip to Kentucky was cancelled. Instead, four of the staff visited a center in

Florida. This center had similar programs and served a catchment area and population of a size similar to the home center's. However, the visited center had a budget that was larger by $1 million, had better facilities, and also had a highly specialized staff.

Each of the observers viewed different programs. These included a satellite clinic, an alcoholic halfway house, a day care center, various therapy programs, and an engineered classroom. Their views of the usefulness of these programs for their own center varied. Aspects of the therapy program, for example, seemed useful. The visitor noted that it might be possible for the home center to train its psychiatric attendants to work in activities with the patients. Other programs, such as the engineered classroom, seemed simply to duplicate existing programs.

Regardless of the usefulness of a particular program, the visitors noted the effects of a larger budget and better facilities. For example, one observer, who said that he would recommend that the home center not start a program such as he had visited, also noted, "If sources of staff funding and program expansion were available, the answer would be, 'Use some of the components of the program we observed.'" The visitors also noted how well the staff of the visited center worked together. One visitor remarked, "The program is constantly sold to the public, and (the agency) cooperates well with the welfare and public health departments." Without exception, the visitors were stimulated and excited by their visits. As one noted, "it gave me a renewed enthusiasm for my job."

In follow-up questionnaires, staff members rated the consultant's visit as "useful," "very useful," or "extremely useful." They were impressed by the consultant's knowledge of programs, by his ability to keep the discussion focused, and also by his pointing out of problems within the group. The visit seemed to raise consciousness about problems within the staff.

But the long-range benefits of the visit are doubtful. Most staff surveyed six months later said that procedures for change at the center had not changed. Most said that no practices from the visit to the other center had been implemented (although a couple of respondents said the center had implemented observed practices--the reason for this discrepancy is unclear). Perhaps this shows that communication had not improved very much.

JONQUIL HOME

Background

Jonquil Home is a private children's residential treatment center and group home for emotionally disturbed children located in a city on the plains. Although Jonquil Home is affiliated with the county mental health center and provides inpatient services for children in this catchment area, it also accepts children with emotional problems from throughout the state.

Other agencies (the county mental health center, a hospital, and a county home) provide the other mental health services for the community: outpatient and emergency services, consultation and education, diagnosis, rehabilitation, precare and aftercare, training, research, and education.

The city's population is about 200,000. Jonquil Home is located in the suburban area of the city, in a residential neighborhood. At one time, it was an orphanage. In the early 1960s, a fire destroyed the orphanage. The community recognized the need for a new and modified program to replace it and gave its support for the construction of a new building and for recruiting a new director. The new residential treatment and group home programs began in March 1965.

The two main building complexes at Jonquil Home are functionally designed. The first building was constructed in 1965-66; the second was completed in 1968. There are four living units of nine children each, two units being located in each building. The living units are structured on the basis of the needs and dynamics of the child and group. Various combinations of children are assigned to each unit; the units are not structured arbitrarily by age or sex.

The buildings were designed with eye supervision in mind. The child care worker has visual access to all the activities occurring in the living area. The worker also has visual access to the outside play areas. The cottages are designed to provide the child in residence with a feeling of warmth, comfort, and security.

The children in residence range from pre-adolescent to adolescent (7-16 years old). The clients represent all socio-economic background levels. Most of the children are referred by the department of social services, and a few from juvenile court. While Jonquil Home functions as a treatment center for all emotionally and mentally ill children, precedence is given to those children with serious problems. Ninety percent of the residents are severely disturbed.

Costs per child who reside in the home exceed $900 per month. The largest portion of funding (80 percent) comes from fees charged to parents, sponsoring courts, agencies, and insurance companies. The remaining 20 percent comes from gifts and endowment income. Most of the construction funds came from foundations, corporations, businesses, and individuals in the community.

Services

Inpatient care for emotionally and mentally disturbed children is the primary objective of Jonquil Home. The treatment is individualized and designed with the child in mind. The favored treatment approach involves psychoanalytic techniques, using both individual and group therapy. Specialists in child psychiatry, psychology, and other related disciplines provide consultation and direction to the overall school program and regularly evaluate the type and course of treatment for each child.

Counseling is offered on an intensive goal-directed basis by therapists on the staff. The therapist sees the children individually or in group therapy two to three times a week and works toward helping the child recognize what brought him here, what he can or cannot do about the problems facing him while in residence, and how to plan for returning to his home community. Emphasis is placed upon assisting the child to develop adequate and workable inner controls that he can take with him and utilize long after he has left Jonquil Home.

Group dynamics are used in the course of semi-weekly group therapy sessions. The group may be composed of boys or girls or a mixed group. They may be regularly scheduled or spontaneous-situational or play therapy groups. A casework therapist is also available to the child on a crisis basis.

There are special education classrooms at the complex for those children having educational and learning problems. These classes are staffed by special education teachers supplied through the city school system and funded by the state department of education. The school has as its objective the return of each child to the public schools, and a part or all of the school day may be scheduled in the public school as the child's needs and readiness indicate.

Consultation and education are offered to schools in the community. One staff member spends 75 percent of his time in the schools consulting on special behavioral problems. He does diagnostic screenings and makes recommendations. There is limited follow-up on these diagnoses due to time pressures and lack of staff. Consultation also takes place with agencies similar to Jonquil Home in other cities in the state.

Precare and aftercare are two other services available to the community. When indicated, the therapists working with the child in residence may continue follow-up sessions with the child and family after the child leaves the program. At the time of the site visit, two children were in aftercare.

Training at Jonquil Home includes inservice training for child care workers and for undergraduate child development students and graduate casework students from the state university. There are eight training sessions for the child care workers. Staff members present relevant and important material to new staff members during these sessions. The graduate casework students receive training from the casework therapists to meet field placement requirements for the MSW degree. To date, ten casework students have been trained under this program.

Staff and Organization

The organization of the staff at Jonquil Home is hierarchical. The director delegates responsibility to three supervisors who are in charge of the three main services: the supervising teacher, who is in charge of the school; the director of clinical services, who is in charge of casework; and the coordinator of cottage life, who is in charge of the child care workers. The director's main functions have gradually moved into the area of community contact and into promoting the program at Jonquil Home for additional funding and limited expansion.

The staff consists of 40 full-time persons and nine part-time persons. The goal of the staff is to develop a therapeutic community, and the attempt to work closely and extensively with parents and children before, during, and after placement at Jonquil Home.

There are five casework specialists and two casework students under the director of clinical services. These specialists are generally MA/MSW social workers or psychologists. They see the children individually or in group therapy two to three times a week, or when crises occur in the life of the child.

The coordinator of cottage life supervises 21 child care workers. The child care workers are usually young men and women with B.A. degrees. They work in the living unit with the child and are available on a living-management level. The child care staff work on a modified shift basis, none live in. There is a problem of status for the child care workers, and because of the stress and strain of the job, a high turnover rate exists. The average amount of time on the job is eighteen months. This problem has been recognized by the senior staff members, who are attempting to restructure the child care worker's job. An innovation currently being tried is sending some child care workers out into the field for preadmission interviews.

The supervising teacher of the school has four full-time special education teachers under him: two at the primary level, one at the junior high level, and one at the secondary level. Two special education student teaching assistants also work with the children attending the school.

In addition to the staff members employed at Jonquil Home in these three areas, two clinical psychologists and one child psychiatrist provide services on a consultant basis for diagnosis and treatment of the disturbed child.

The director's management style is one of delegating maximum responsibility to the three program directors, who in turn delegate much responsibility to their staff. While the director supervises activities, it is not necessary for him to be involved in day-to-day decisions made by the staff. A great deal of trust and communication exists between the director and the three program directors. The director feels the staff is highly qualified, and they work extremely well together. He states that in order to have a good working relationship, people must be able to work together. This trust and support for his subordinates has freed him for more direct work in the community.

Most decisions are arrived at by group consensus. When conflicts arise, the staff from one of the services meet with their supervisor to discuss the problem. If the problem is unresolved, a session is held with the director where more discussion occurs and a decision is finally reached. The director views conflict as part of any center's life, and as something to be dealt with. Normal conflict is not seen as an indication of unusual problems or difficulties.

Communication among staff members is viewed as a key element that has made Jonquil Home an innovative and effective mental health agency. Therapists have weekly conferences with the child care and education staff that focus on the child. These meetings present an opportunity for discussion and review of new ideas. In addition to these conferences staff frequently refer to a log book containing a 24-hour record on the care of each child. Any staff member may quickly glance over what activities have taken place with each child on the shifts before he or she comes on duty. This has been an effective, efficient way of keeping track of each child's behavior.

Consultant at the Center

Much of the visit was spent learning about Jonquil Home, its history and programs. The visit began with a tour of the facilities, which the consultant and the AIR representative felt was complete, with no attempt to hide things or leave them out of the tour. After the tour, the supervisor of clinical services described the center's goal (to develop a therapeutic community), procedures, policies, and the center's major problem: the child care workers' feeling of low status. It was to counter this feeling, the director said, that the workers were asked to do preadmission interviews in the field.

In the afternoon group meeting, the center staff gave a full description of the center's programs. The consultant did not feel tensions within the group. When problems did arise, they were solved by the group process. The supervisor of clinical services has accepted the idea that there will be problems within the staff, a mature understanding, the consultant thought. The visitors were struck by the full participation of the staff, down to the administrative assistant. One staff member noted, "We trust each other." The consultant shared this perception, and felt moreover that it was one reason the center is so successful. The discussions the next day continued to bear out this feeling.

Visits by Center Staff

During the consultant's visit to Jonquil Home, no definite decisions were reached as to who would be going on the site visits or which sites Jonquil Home staff members would be visiting. Senior staff members recognized the need for paraprofessional staff to participate in the visits, and one type of program the staff indicated visiting concerned the role of child care workers. A general staff meeting was held shortly after the consultant's visit to discuss the site visits. A decision was reached by group process to visit two agencies providing care similar to that offered at Jonquil Home.

Site Visit 1. The director of cottage life and eight child care workers visited another private residential treatment center for emotionally disturbed children. This center provides residential treatment, day care treatment, and aftercare services through the facilities of its individual and group foster home department. Special education, milieu therapy, and psychotherapy are integrated into one therapeutic program.

During their site visit, Jonquil Home staff observed the campus school, cottages, and segments of the administration. The main emphasis of the visit was on the child care program and cottage organization. The role of the child care worker was explained by the child care workers and supervising staff.

Although the program at the visited center is very similar to the one at Jonquil Home, it does focus more on a child's behavior rather than emphasizing the psychoanalytic process. Jonquil Home staff indicated that this aspect of the program might be helpful for their agency. They felt this approach prepares a child more directly for the real world environment.

One aspect of the program at the visited center that might not work at Jonquil Home is the amount of freedom the child has in what happens to him and how much he thinks he can handle. Since the children at Jonquil Home are more disturbed than at the visited center, the child care staff thought this practice would be less effective.

A regular staff meeting attended by ten staff members was held when the group returned from their visit. The overall general reaction to the visit and the program they observed was positive and the discussions indicated an interest in implementing those aspects of the program regarding treatment approaches to child behavior. In addition, the visited center's program was directed toward child care staff and involved activities that were of interest and relevance to the role of child care workers.

Site Visit 2. Another private residential treatment center for children with severe personality and emotional problems was also visited. Individual psychotherapy is an important part of the program. Education is provided at the center on both a class and a tutorial basis, but it is less academically oriented than the program at Jonquil Home. The average duration of treatment is longer (three to five years) than for the children at Jonquil Home (six months).

Jonquil Home staff observed three aspects of the program to discuss in planning for change. One aspect concerned the school arrangement and facilities, and the strong teaching staff. Two other practices for future consideration were the longer staffing conferences and the child care resulting from these conferences.

There are no security (or control) rooms, and medication is not offered as part of the program at the visited center. Staff members from Jonquil Home felt they would have difficulty handling certain children without the availability of these two services.

Observations and reactions to the visited program were reported at regular staff meetings. Discussion regarding the visit resulted in an awareness of the need for more opportunities to visit other centers and confidence in the value of their program.

Both visits have stimulated thinking at Jonquil Home about new ideas for their program and have increased the recognition for the need of evaluating their present programs.

KEELER CENTER

Background

Keeler Center is a medium-sized urban mental health center located in the Southeast. Located in a city of 57,000, it serves an urban-suburban catchment area of 175,000 people. The median income of the catchment area is slightly above that of neighboring areas.

During the 1950s, the local child guidance clinic and an adult guidance clinic were combined into one agency. In 1968 this agency officially began operation as a comprehensive community mental health center. Since then, the center has experienced a rapid growth and expansion. The staff and budget have tripled during this period, due to increased funding and the addition of new programs. In 1973, it was projected that the center would have 120 full-time staff members, with an annual budget of more than 2-1/2 million dollars.

Keeler Center officially operates as a private nonprofit corporation. Local and state governments and federal grants are the major sources of funding. The local Junior League and other charities also provide a set amount of funds annually for the support of one specific program. Most of the services provided by the center are located in a well furnished modern facility. The drug abuse and alcoholism programs operate from separate facilities, each of them slightly older, located a few blocks from the main complex.

Services

The center provides most of the services offered by comprehensive community mental health centers. Inpatient services are provided by three local hospitals, and some rehabilitation services are offered in cooperation with a state agency. While a variety of services are available, primary emphasis is placed on five basic programs. These programs--learning disabilities, alcoholism, drug abuse, day treatment, and outpatient and crisis intervention also indicate the organizational structure of the center. Each program has its own director and staff.

The center actually operates as an umbrella agency to these five independent services. Center staff provide bookkeeping and administrative functions for the five programs, each of which has its own philosophy. There is no centralized intake to provide information about previous contact with the clients being served. Theoretically, it is possible for a client to be seen by each of the five programs without anyone being aware of the duplication.

Each of the programs has its favorite treatment approach. Most of them use behavior modification techniques, but extensive use of all types of group therapy is also found.

The type and number of services stressed at the center seem to relate to the amount of funding available in particular areas. The local Junior League has supplied funds to be used in the area of learning disabilities, resulting in the creation of a learning disabilities clinic which occupies a large wing of the center complex. Two other recent programs for which funds were available are drug abuse prevention and alcoholism counseling. Both of these programs were established after grants were received from the federal government. These three programs account for approximately 75 percent of the staff. The other two programs, day treatment and outpatient/crisis intervention, are smaller both in terms of staff and patients.

The operating system of the center does not encourage the center to assess its needs or its role in the community. There is no pressure to develop a centerwide philosophy, so none exists. Keeler Center has developed programs where federal funds are available, not in response to local needs. Although the community may have greater needs, if no funding is available to meet them, the determination of local priorities remains an academic exercise. For Keeler Center, expanded outpatient services and a geriatrics program are major needs of the community, but development of these programs, according to the director, depends on funds being available.

Staff and Organization

Key staff include the five major program directors, plus administrative staff including a center director, in the central office. The program directors are responsible for the decision-making in their own programs. Clinical judgments, program activities, goals, and evaluation are done independently for each of the programs.

The staff has a high degree of professional training. All but two of the program directors have Ph.Ds. Most of the remaining professional staff have MSWs. In the last few months, paraprofessionals have been employed in the drug abuse and alcohol programs.

The center director has the ultimate decision-making authority. He has responsibility for overall center functions and future areas of program development. The center still operates as if it were a small center, in which the director makes all final decisions. However, the recent expansion has caused the director to question this structure and think about alternative methods of administration and management.

The administrative staff has no group decision-making responsibility. They go to the director individually with suggestions and recommendations, but the director makes the final decisions as to what changes take place at the center. The decision-making process is more authoritarian than democratic.

However, this authoritarian approach is not considered ineffective by many of the staff. Many of them feel that the director should make the decisions and that staff should not participate in that process. With this approach, staff take responsibility for day-to-day decisions in their own programs, but the director alone focuses on centerwide goals and priorities. Several staff members indicated they felt this approach was best.

Because of the size of the center and the geographical distance between programs, there is little communication among staff members. A general staff meeting takes place once a month, and an administrative staff meeting with program directors occurs once a week. Both of these meetings serve as an opportunity to exchange information.

Current Situation

The director and the program directors view needs and pressures of the center differently. The director sees survival and the acquisition of additional funds as the number one need of the center. The pursuit of additional funds is his main activity; he fears the center might lose programs or be closed because of the unavailability of federal funds. The director is aware of the problems created due to the growth of the center and considers alternative management styles as a priority, but one that is second to funding.

The program directors each see the needs of the center from the perspectives of their own programs. The director of one program, learning disabilities, concurs with the center director on the major area of concern. Because of the rapid growth and expansion of his program in the last year and the lack of federal funds, he sees funding as the center's main priority. The director of outpatient and crisis intervention sees more formal evaluation of the programs as the biggest need. He would like to have someone monitoring his group's activities in order to give them more direction and feedback on what they are doing.

The director of the drug abuse program cited two concerns: the need for staff development and the lack of a centralized information system which would allow the staff to make use of previous data on clients in providing services.

The director of the day treatment program cited three needs: going beyond day treatment into areas of goal orientation for all program staff; setting up a system of expectations regarding change and monitoring whether change occurs; and establishing a structure for evaluating programs. The director of the alcoholism program would like feedback on his program, especially feedback which would assist on staff development.

The staff is willing to discuss problems of the center as a whole, but they are not willing to take responsibility for solving these problems. The main reason for this is the structure of the center. With each program limited to its individual concerns there is no incentive to work for the center as a whole.

Consultant at the Center

The consultant was the director of a large complex of centers in a southern city. His style emphasized group process. He was very sensitive to feelings and reactions of the group members. He was friendly, warm, and casual.

The initial interview with the director dealt primarily with facts. The purpose and goals of the visit were explained again. The material to be covered in the staff meeting was explained and the director gave his permission for this discussion. The director said that eventually the staff should make a recommendation to him about how to spend the $500 travel stipend and he would make the final decision.

Individual interviews were held with key staff: all five program directors, the business administrator, social workers and psychologists. In addition, two group meetings were held with most of these people in attendance. Several themes ran through their conversations. These included the director's specific management style, identification of center priorities, and concerns of each individual. The impetus for the discussion was consideration of components present in change. The consultant mentioned examples of resources and limitations, and the group took off from there.

The center director's statements were especially interesting. To some extent, his concerns are probably the concerns of all center directors, as well as hospital or agency directors--the confusion over funding and survival of the center. At the time of the visit (spring 1973), the outlook for continuation of community mental health centers was precarious. There was confusion about federal funding prospects-- no one seemed to have a clear idea of what was happening. This director's confusion, frustration, and apprehension were characteristic of the mood in most centers in the country.

The director's role was clearly that of a PR man sniffing for leads to funding sources. But this concern appeared to eclipse concern for community services, staff satisfaction, and personal development. Some of the staff realize this; they openly expressed a concern for staff development and training rather than seeking funding sources. One or two people felt the program should be responding to community needs rather than being based on funding priorities. However, a sizeable group echoed the director's concern about survival and funding sources as well.

Throughout, there was a pervasive attitude of complying with decisions made elsewhere. The administration felt they had no choice but to respond to funding decisions made at a federal level--these decisions determined their programs. The program directors felt they had little participation in decisions affecting the center. They presented their cases to the director and then complied with his decisions. When the consultant suggested that they might participate in these processes, they said they were comfortable with the status quo and had no real interest in modifying it.

In his initial interview with the director, the consultant had explained the group process and participatory situation he hoped to bring about; he had asked the director whether this would be an appropriate method at this center. The director commented that it would indeed be appropriate and would present no problem. When the situation actually occurred, it became clear that it was indeed a problem. (The director said that staff participation could be carried "too far.") Yet there did not seem to be a general current of dissatisfaction among the staff. Some members certainly had some problems with this director's style, but a sizeable number supported it. The director's reactions were well known and the prediction of how the travel stipend would be spent ("the director will decide how to spend it") was accurate.

There was little concern with community needs, expectations, or problems. Again the apathy because of not being able to do anything about them without funds was operating here. During individual interviews, several people mentioned needs for a geriatric program, consultation to community agencies, an intake procedure, common record keeping, evaluation, etc. But no serious, unified attempt was in evidence to meet those needs. Further, in a community where 20 percent of the population comes from minority groups, there were no minority members on the staff and no programs directed towards the minority population.

There was no clear plan about what directions the staff wanted the center to go. Expansion occurred with little prior planning as to where additional services might be needed.

Visits by Center Staff

During the consultant's visit to the center, no definite plans for site visits were made. It was clear the director would make the final decision regarding site visit selection. The director indicated an interest in observing management techniques at centers that had undergone rapid expansion. Funds for the director's visits would come from sources other than the $500 provided by the AIR-NIMH research project. The consultant mentioned programs using team management techniques in addition to other types of management styles as possibilities for the director to visit. Two or three specific programs were suggested by the consultant but there was no follow-up on these visits by the director or consultant.

The director informed the consultants that the program directors would have the opportunity to suggest other programs they would like to visit. The staff was aware that the director would make the final decision regarding these visits.

A visit was made by the learning disabilities program director to two mental health centers in the Northwest. No information is available on why these centers were selected.

At Center 1 the site visitor observed a volunteer telephone program, data collection procedures and inservice training techniques. The visitor indicated that all of these programs were potentially useful for Keeler Center.

Day treatment program and emergency services were observed at Center 2. The residential facilities used by the day treatment program and the extensive use of community resources were pointed out as useful aspects of the program.

The psychiatric emphasis of Center 1 and the extensive social work orientation of Center 2 were regarded as aspects of the programs which were not appropriate to Keeler Center.

At Keeler Center, a program staff meeting was held after the visit, and was attended by all program and administrative directors. They indicated some interest in the practices but decided these would be of little use to their center. According to the staff visitor most staff are satisfied with their existing programs.

The site visitor reported gaining a new perspective on the functions of his center because he was not emotionally involved in the programs he observed. He commented that he would like the opportunity to visit more centers.

LITTLE CENTER

Background

This small mental health clinic is located in a rural area of Region 3, in a town with a population of 17,500. Its catchment area covers two counties, with a population of nearly 100,000. The clinic is in a downtown medical office building, lending it the aura of a "treatment" center and reinforcing its medical mode of functioning.

The clinic opened in May 1964, without federal funding, and is responsible to the county government, which is represented by a board of directors that makes most policy and financial decisions for the clinic. Last year it served approximately 5,000 lower-middle class patients.

This rather conservative community appears to have adverse feelings about treating mental patients in the community; alleviating this attitude would lessen some of the pressure on the clinic.

Funding appears to be handled mostly through the county, and the staff seems quite unaware of and even unconcerned about the details. They have little to do with fiscal planning, or any of the other financial problems mental health centers usually must wrangle with. A local banker, a member of the clinic's board of directors, handles all the financial dealings for the clinic, including an annual budget of about $100,000.

Services

As mentioned earlier, the clinic follows a sort of "medical model" in its day-to-day functioning--reaching out to "cure the sick"--although individually, staff members say they wish they did not. Nevertheless, the staff see themselves as a model to be followed, primarily because even with a small staff (five professionals and an office manager) they began reducing the population of their state hospital (through their programs) before others did. Little preventive work is done; practically no formal consultation or outreach is attempted.

The clinic offers psychiatric outpatient services: diagnostic evaluations, psychotherapy, group therapy, family therapy, chemotherapy, emergency 24-hour service, aftercare services for patients released from state hospitals, interim care for mentally retarded persons through the county administrator, and short-term hospitalization in the local general hospital and long-term inpatient hospitalization at the state hospital.

However, the consultant noted that the staff does not seem to be utilizing any new techniques. Asked to list new practices introduced during the past two years, the director mentioned only "electroshock therapy."

Staff and Organization

The clinic is headed by a medical director, but administration within the clinic is as much a group decision-making process as one could wish; almost all decisions not made by the board of directors (which makes practically every major decision involving program planning and finances) are made by the clinic staff members together.

The office manager, a "home town girl," is more politically aware than the others seem to be, and consequently, has a great deal of power. The chief social worker seems to be the leader to whom the group turns for answers or advice. The medical director delegates responsibility, as long as he is consulted if any questions at all arise.

Other staff members include the chief social worker, who is being groomed to become administrator of the clinic; a social worker responsible for individual and group therapy; an MR social worker; and a registered nurse who assists with inpatient work, sees outpatients and runs the day care center. Honest two-way communication exists among all the members of the staff, and they work together as a family. There has been little staff turnover in recent years.

Current Situation

The clinic's biggest problem -- although they had not yet realized it -- seems to be the political naiveté of its staff. The consultant sought, through various suggestions, to make them aware of various ways in which the clinic could broaden its power base of agencies who are dependent on the clinic -- such as the sheltered workshop, which receives 80 percent of its clients through referrals from the clinic; the state visiting nurses, who should be shown that the clinic supports them; and the Children's Aid Society, which could be encouraged to take all the cases that are not pathology. By enlisting these agencies on its side, the clinic would gain strength, visibility, and credibility in the community, which would be helpful in political and fund raising endeavors.

The center staff is aware of the need for better relations with other community agencies. The staff is already concerned about an uncomfortable working relationship with the schools and the other "helping" agencies in town -- particularly the sheltered workshop. Some of the staff feel the sheltered workshop keeps clients longer than it should because as the clients' conditions improve, they become the most productive workers. The consultant recommended that clients be sent to the workshop with a predetermined course of treatment, limiting the length of time each client can spend there.

Most of the other agencies in town do at least call before referring patients to the clinic. The clinic has good working relationships with the physicians in the county, partly because the clinic ostensibly follows a medical model, and partly because the medical director used to be an old-time general practitioner, and relates easily and well to the other doctors.

Another pressure the clinic feels results from two drug treatment agencies which operate in the community. Clinic staff are reluctant to refer patients to them because they don't feel their "treatment" is appropriate. With a legally mandated need for drug treatment centers -- the law says drug offenders cannot be jailed, but must be "treated" -- the consultant suggested the staff make referrals to the two agencies with a planned program and the power to evaluate the treatment and the client's response. The staff was very receptive to the idea of a planned program for change in this area.

Consultant at the Center

The staff of the clinic welcomed this visit by the consultant, and eagerly asked questions, tossed out suggestions, and discussed possible solutions to some of their problems.

The consultant, who is from a rural area himself, described his center and its programs to get the first group meeting started. This led to a discussion of the history of the clinic, and how its past was contributing to some of its most pressing present problems. When asked for advice or specific suggestions he always had a positive offering. He was especially able to point out how the clinic could build a strong sociopolitical power base in a manner that was entirely feasible and compatible for that particular community. By asking the group to identify other community service agencies, he made them aware of the wealth of resources available to them. Another problem he pinpointed was the need for clearly defining the role of the local mental health authority.

After his visit, the consultant wrote a two-page letter to the clinic, summarizing the points he had made during the visit. He emphasized that the points were feedback items, rather than criticisms, and said he hoped the staff would use them as starting points for continued discussion.

He made four main points in the letter. He suggested: (1) seven ways to broaden the clinic's sociopolitical base; (2) that consultant meetings be scheduled on a regular basis to serve as a "mirror for your center's goals and progress and to help solve specific problems or program needs," (3) that referrals to the sheltered workshop be made with a predetermined treatment plan, and (4) that consideration be given to changing the name of the clinic.

The consultant appeared to motivate the staff to think about change, and to set priorities in the goals. Apparently quite a warm feeling developed between the staff and the consultant, and on follow-up questionnaires, all staff members rated his visit as very or extremely useful, with comments suggesting that they either would have liked a longer time with him, or follow-up visits.

Visits by Center Staff

The entire staff participated in choosing the mental health centers to be visited with project funds. "We arrived at these selections through a general staff conference with ideas for improvements within our program being considered," the office manager wrote to AIR. Three staff members visited the two sites in the same state, and three members visited the third site in an adjacent NIMH region.

Out-of-state Visit. Each of the three staff members who visited the center in another state observed a different program, and was guided by personnel from that program. The general feeling of the visitors was that the center, which serves a large, five-county rural area, was extremely well organized and efficiently meets the needs of the community. They were impressed with the extensive transportation system for the summer program for trainable MR children, and with the efficient planning and leadership provided by the director. The two centers, however, are quite different, and there is probably not much possibility of extensive overlap of programs or techniques.

In-state Visits. The first center visited in the clinic's home state was also quite dissimilar from their own. Located in a city of nearly 60,000 people, the center has a staff of 105 persons (compared with the five-member staff of the clinic). It does, however, also serve a two-county area. None of the three visitors felt the treatment programs would be adaptable to their own small clinic, but apparently did feel that observing their business office procedures and public relations programs provided some insights that would be practical and beneficial for them. The clinic director noted how the large center was handling some of the problem areas that had been pointed out by the AIR consultant at his own clinic, such as gaining county acceptance and support, obtaining multiplicity of funding, and contracting with other agencies to provide services.

The third center visited, also in the clinic's home state, is a nationally known medical referral hospital and clinic which has added an MH/MR component. Its "primary interest continues to be teaching and research," one visitor noted. Even so, he added, "I feel our clinic offers comparable quality treatment, and this was reassuring."

Apparently the visits for these staff members to larger and more diversified centers did underscore and add credence to the points made by the consultant during his visit, and reinforced his recommendations.

All five staff members attended the meetings in which the visits were discussed, and although the general reaction seemed to be, "They're too much different from us to adopt their treatment programs," the staff expressed a definite renewal of interest in stimulating outside program and funding support, both from the local community and federal sources.

MESQUITE CENTER

Background

Mesquite Mental Health Center is a private, nonprofit corporation located in the Southwest. Its catchment area, extremely large, comprises seven counties with a total land area of 33,000 square miles. The population of this catchment area is 165,407. The ethnic breakdown for the counties is as follows: Anglo 52%, persons of Spanish language 43%, Black 3% and Mescalero Apache 1%. The economic status of the center's clients is low; 65 percent of them earn less than $7,000 per year.

Originally, Mesquite's current building was a nightclub. The center, which opened in 1969, has always been weak financially. Its annual budget is approximately $575,000. With this budget the center operates an alcoholism treatment program, drug abuse program, counseling services (which includes hospitalization for severely disturbed adults), consultation and education services, and youth counseling services. Mesquite spends a large percentage of its budget on personnel. This fact, combined with low salaries, means that Mesquite is able to offer a large number of services.

In the 18 months prior to the visit, the center grew tremendously. Its original staff of 18 increased to 48. Until recently, few of these were minorities. One consequence of this was that the large Chicano population in the area did not come to the center in proportion to their number in the community. They preferred to seek help from the local priest rather than from the center.

Services

In order to serve a large, rural area, the original board of directors adopted a plan analogous to the county agent model. In the first of three stages, the aim was to build a small core of professional mental health workers. This was a problem. Recruiting credentialed mental health workers in the area is difficult and expensive; but a minimum of professionals is needed to train and supervise others and to handle certain more difficult problems. Because they must often be imported, the professionals lack familiarity with and commitment to the locality. Mental health workers indigenous to the area possess the necessary community expertise but lack the training and background of the traditionally trained professional. The board chose the county agent model to attain the necessary balance of community commitment and technical mental health expertise. Under this model, the center maximizes the clinical skills of its professionals by assigning them to train and supervise a larger staff of non-traditionally trained mental health workers who are knowledgeable about the geographical area.

The second stage of the plan called for placing of an indigenous mental health worker in a field office in each of the seven and one-half counties. With funding from the National Institute of Alcohol Abuse and Alcoholism and the Office of Economic Opportunity, the center was able to enter the second stage of the plan.

During fiscal year 1971-1972, implementation of an alcoholism program began. Two professional mental health workers--a director and a consultation specialist--were recruited to work out of the central office. They attended workshops and a six-week course in alcoholism at an area university.

Trained to do individual, group, and family counseling, the alcohol abuse workers--like county agents--are capable of handling many mental health problems. When they need to draw on the resources of the central office, they request consultation or else refer clients there for direct services.

The workers operate out of one or two field offices in the major towns of each county, often in space donated by other service agencies. Their relationships with local resources are especially important because they use agencies such as health and social services, vocational rehabilitation, and Alcoholics Anonymous to serve their clients. The workers also provide consultation, information, and education services to law enforcement officials, physicians, schools, and the general public. The focus of these sessions is alternatives to traditional methods of dealing with alcoholism. Workers can arrange emergency services through local physicians who work on a part-time basis for the center. Short-term hospital care is available through center-hospital work agreements in several towns. When extended residential care is indicated, workers refer clients to the center's halfway house, which is operated by a registered nurse and a live-in house manager.

The alcoholism program staff receives continual inservice training, including a weekly clinical staff meeting conducted by the center's medical director and periodic followups at the university. The final stage of the master plan involves establishing regional satellite centers--tied by policy to the central office and programmatically designed to respond to special target group and community needs.

In April 1972, the center entered this stage with the opening of a youth counseling center. The counseling center is designed to offer crisis intervention, short-term therapy, and consultation, education, and information services. Although the counseling center emphasizes youth, it also gives space to the county alcohol abuse worker, a drug abuse worker, and the coordinator for state hospital precare and aftercare services.

The community has responded positively to the counseling center. Two organizations of concerned citizens serve as advisory groups. The public schools have opened their doors to a counseling center drug survey, designed for use in planning a drug abuse program. In its short existence, the counseling center has established some credibility as a resource. Seven agencies and groups, including health and social services, juvenile and adult probation, the public school system, physicians, and ministers, have made 17 referrals. In the future, as the program expands and community support strengthens, the counseling center will be more capable of providing comprehensive services to the entire eastern region of the catchment area. Mesquite's long-range goal is to establish a similar satellite center in its western region.

Staff and Organization

The director of the center is appointed by a board of directors. Under him is the medical director, who is responsible for the clinical operations of the center. The center's structure is comprised of five program elements: youth services, adult services, the alcoholism treatment program, drug abuse program and the youth counseling center. Within each program, emergency, inpatient, outpatient, partial hospitalization, and consultation and education services are provided.

The center is further divided into 14 sections, with one to 28 members in each section. These 14 sections make up a decision-making group, with each section having equal representation regardless of size.

The background of key staff is limited. The director is a psychologist with a Ph.D. After this, staff's formal qualifications are minimal. The director encourages his staff to make their own decisions; he usually abides by the outcome. When he notices a group getting frustrated, he will sometimes make the decision.

The organization is undergoing a change in management style. It wants to change from the personal type of management of the director to an organizational hierarchy approach. There have been problems adjusting to this new approach. Part of this stems from an increased staff size, and from more responsibilities taken on by the satellite centers.

Communication breakdown is another problem. Last year, section heads met for a two-day retreat to discuss these problems, and also to discuss short and long-rage goals for the center. This practice is now a regular procedure: a two-day retreat to air out feelings, to solve problems, and to set goals. Not enough contact was made with staff to get their feelings about their jobs.

Consultant at the Center

The consultant held a series of meetings with individual staff members to learn about the center's history, programs, and plans. Much time was spent discussing the alcoholism and drug abuse problems.

At the group meeting, the consultant began by discussing change as a process. This led to the issue of the role in the community in setting priorities for change. The center had had what it considered a depressing experience in involving the community. It called an open meeting, but those who attended all had vested interests in pushing one objective or another. The common people, those who might use the services, did not come. However, the center does have an advisory board for each county. These boards, which vary in sophistication, sometimes cause problems. However, these problems are not major, compared to the overriding problem of survival.

One technique the center had used to deal with its problems was a one-day retreat, headed by all section heads and a management consultant. The retreat had several aims to give section heads a bitter feel for funding limitations, to recapitulate the philosophy of the center, to discuss objectives, and to set priorities and programs. There was not enough time to cover all these topics, and as reviewed at this meeting, reactions to the retreat varied. Some staff considered it a waste of time, not worth the considerable expense. Others found it worthwhile. The director was enthusiastic. He thought there would be great benefit in holding a regular retreat. It would be one way to solve a major problem in innovation: bad planning or lack of planning.

A large part of the discussion dealt with what kind of center to visit. A number of suggestions were made. Finally the director mentioned the problem of ethnic participation, because of the concern about the lack of Chicano clients at the center. The concern eventually became the object of the site visit.

Visits by Center Staff

The staff made three site visits with the aim of developing mental health services for its Chicano population. These three sites contained a large population of Chicanos and Latin Americans.

Site Visit 1. The first site is located in a rural area. The area surrounding the center has a heavy concentration of migrant and seasonal workers who are recent arrivals from either Mexico or other parts of the country. It is funded by the county and NIMH. Several social agencies are housed under one roof. Health and social services, food stamps, probation, public health (immunization and birth control), human resources (state employment office), etc., are housed here. These services work closely together. People refer clients to other agencies by merely walking down the hall and introducing the client to the agency or person who services that particular problem within the building.

The visitor was especially interested in the community worker program. The visitor felt that the staff at Mesquite was not reaching the real poor people

(Spanish speaking) in the area; a community worker program might help alleviate this problem. The community workers at Site 1 have a wide range of activities, which include group work in schools for students suffering from peer and other social problems, home visits to clients referred by the probation department or the court, and working with job trainees at Opportunities Industrialization Center (OIC). In all these activities, community workers go to the clients instead of waiting for clients to come to them. Contact is made in the home because most Chicanos in the area are reluctant to go to the center.

One particular community worker was singled out for his outstanding work. He is active in the economic upgrading of the county and in developing resources at the county level. He has assisted in organizing cooperatives through which a large group of families can generate their own economy and become self-sufficient.

Site Visit 2. This site, also rural, provided two areas of interest. One was the local citizen's board, the result of a mandate from NIMH to involve the community. This board consists of Blacks, Chicanos and Anglos who meet with the functional units of the center to discuss the problems of those units. When this board was formed, it attracted a lot of interest from the community, and it included both mental health professionals and non-professionals. But non-professionals began to feel "threatened" by the professionals, and interest from the community dwindled.

The other area of interest was the community worker program. This program is a little different from Site 1. A worker's hours are broken into 8 hours for meetings, 16 hours for work in their assigned unit on the team, and the remaining 16 hours for work in any one of the other service units. This broadens the individual's own work experience. Also, as in Site 1, the community worker is allowed a certain number of hours per week to attend school, which helps the center develop expertise from within the community.

Site Visit 3. The last center visited was an urban center, in an area comprised primarily of Latinos. This center is funded by the Office of Economic Opportunity (OEO) and is free of charge to anyone seeking services. It houses both public health and mental health services.

This center uses family health workers who reach out to the community. Their job is to perform specific health and social work services in the health center and the patient's home. They work as patients' advocates between professionals, schools, and other agencies. The center operates under a philosophy of total health; thus the family worker may be involved with a variety of tasks related to the total health needs of the person.

Family health workers are trained not to label each patient because this only isolates the patient from the worker. Basically they are taught to be real, to listen totally, thereby to discover what is bothering the patient.

Reports to the Home Center. The reports of these three visits were given at Mesquite's regular staff meeting. Out of 34 staff members attending, only five or six showed some sort of interest. The rest had no opinion. The visitors believe this reaction occurred because Mesquite is a traditional facility, one where patients go to the center to be treated, as opposed to a center where staff go into the community. As a result, the visitors feel, the staff had no point of reference for seeing those innovations as being possible at Mesquite.

NIMROD HOME

Background

This facility is not a community mental health center but a residential treatment center for children. The home is situated on the edge of a middle-sized conservative town in the Midwest. There is no defined catchment area -- the home accepts children from all over the state. Over half of the residents come from a metropolitan area 250 miles away, even though there are similar facilities closer. The home has a staff of 40 and commands an annual operating budget ranging between $250,000 to $500,000. The ownership is private and the agency does not receive any federal funds. It is sponsored by county welfare agencies.

The center was opened in 1916 as the Children's Orphanage. All operations are conducted in a building constructed in 1922. Currently a large new building is close to completion. All existing operations, along with new programs, will be transferred to the new building upon completion. Construction is partially funded through a building grant from NIMH. The home is located in the country on a hill overlooking the forest on the outskirts of town. It is situated away from the community, with no signs on any approach roads stating its existence. Even though it is a residential home for children, there have never been any recreational facilities. In the new building craft shops are planned, but as far as physical activities are concerned such as swimming, basketball and indoor sports, there is no gym, pool or anything else of this nature planned.

The children who attend for treatment are generally from a middle-class background. Minority cases are few. Out of 40 present there were one black child and five native Americans (Indians). The length of treatment ranges from six months to two years, with the average length of stay being one year. Most treatment is paid for by welfare agencies.

There has been increasing pressure to increase community interaction. Even though the surrounding community has a populace in the 100,000 range, there is only one child from there in residence. There has also been pressure to develop community related services.

Services

Opened in 1916 as an orphanage, this home has had a long history of institutional services and treatment approaches for children. This center was a forerunner in many changes concerning services for children. There are two different types of treatment approaches: one a humanistic approach and the other a behavior modification type approach.

Approximately 40 children are under residential care. They are divided into groups of six or seven children. These children are then placed into either of two groups -- one a therapy or treatment group, which is conducted by staff members who are social workers. The other group is called the program group, the main function of which is to help the children with their living problems. A child psychiatrist is present as required by state law, but he is not used effectively because individual therapy is not stressed at the home.

All services are done within the confines of the center; there are no satellite centers or outreach programs working with the center. There is no follow-up after any child is released. A halfway house is the only outside affiliation the home has. These two facilities share staff, but the halfway house is completely separate from the center.

Staff and Organization

The director and three staff members are the key staff. One is the administrative assistant. The other two do not have specific job titles on the administrative level, but they are very influential with the rest of the staff. These three meet informally together when the need arises and they all share the same common views. There are no regular staff meetings for all staff, only informal ones.

In charge of each group of children is the group leader. The group leaders have a masters degree in social work or in psychology. These group leaders have considerable flexibility in program planning for their children and they have authority to make final decisions regarding individuals in their group. These group leaders are very involved and have a sense of responsibility to the work that they do. In general, all staff are quite involved in their work at the center, and there is a low employee turnover rate.

The director, who has a masters degree in social work, uses a democratic management style, allowing his key administrative staff to make many of the decisions. He makes sure that staff has a good knowledge of other programs, and frequently visits are made to other facilities to observe their programs. A state association of residential facilities meets periodically allowing staffs to exchange ideas.

Despite the good relations among staff, and because there are no regular meetings among all staff, communication is a problem. Key staff meet informally with different levels of staff, but they do not meet regularly on all levels. The administrative assistant is striving to end this communication problem with the inauguration of sensitivity groups, and a log book is being kept to record all staff comments.

A feeling of separation exists between program and treatment staffs due to work shifts being back to back. Rescheduling work schedules so that they will overlap will now remove this barrier.

Current Situation

The main problem facing the center is one of not being involved in the community. The contact between the two is minimal. As mentioned before, very few children are in residence from the surrounding community, even though its population would dictate more. There are no road signs leading to the home, and the community has never been invited to visit the home. Also there seems to be no interaction between the home and the public school system, except for teachers and group leaders talking to each other about children's problems. There is no community advisory board. This further alienates the home from the community. The director is aware of these public relation problems but does not spend time on them. He does not solicit for funds and this keeps him further removed from the community. He does not advocate the hiring of community liaison persons to bridge this gap.

Help is needed in staff development, staff programming and staff planning, and this need will become more acute when the new facility is completed.

Consultant at the Center

The consultant, a director of a midwestern mental health agency, has a wide range of experience in counseling. He is very open and he attempted to talk to as many levels of staff as possible. Throughout the visit he did not focus on any particular subject -- he was looking for a total overview of the whole facility. To obtain this, he encouraged all staff to provide input.

Shortly after the visit, he sent a letter to the director thanking him for his hospitality and cooperation. He also highlighted the important problems of the center and offered suggestions on how to improve them. He designed an organizational chart and suggested certain positions for certain members of the staff to fill. He talked about the development of a community advisory board which he stated would help the home relate more to the community. Staff training was mentioned with the suggestion on how it could be improved. The consultant felt there were many good points at the home and did not hesitate to compliment the director on these.

Visits by Center Staff

Three staff members were sent to visit other facilities, two attending a conference of child care workers from throughout the state, and the others spending four days observing programs at another residential institution.

Conference. The child care workers' conference was held at a retreat camp, and was sponsored partially by one of the state's children's home. A special guest presented his model and ideas concerning child care work in residential treatment -- milieu setting, establishing working cultures in residential treatment techniques for and of life space interviewing, activity planning, and behavioral management. He felt children developed problems through lack of competence in the areas of internal, intrapersonal, and environmental situations. His models were illustrated through lecture, discussion, and role playing. He felt that institutions should be living, learning education centers.

The visitors paid particular interest to the behavior management techniques and life space interviewing since they fit the center's philosophy and are presently employed by staff at the center.

The other site visitor went to observe family counseling and life style analysis. Only certain aspects of the programs could be used at the center, the visitor felt, because of an insufficient number of people trained to administer full programs.

ORTEGA CENTER

Background

Ortega Mental Health Center is located in a small city in the Midwest. The center's catchment area is approximately 52,000. The annual budget for the center is between $250,000 to $500,000, which supports a full-time staff of 21 employees. The center has been in existence since March 1970.

The community is affluent. The city's major industry gives its employees excellent medical coverage, including outpatient psychiatric coverage. Because of the affluency of the center's catchment area, there are usually no major problems in obtaining operational funds.

Services

Housed on the same grounds are two separate institutions. There is a community hospital, which includes the mental health unit that specializes in inpatient day hospital and to a small degree, outpatient services. Also on the grounds is the mental health clinic which handles outpatient services (85 percent), some consultation (5 percent) and administration.

At present the community hospital is involved in a multi-million dollar expansion program which will include the clinic. The clinic is housed in temporary trailer buildings with the staff operating in small, crowded rooms. Expansion plans call for the clinic to move into the hospital. When this happens, the clinic would lose its autonomy and would be subject to the hospital. The clinic would prefer to remain separated from the hospital to keep administrative conflicts to a minimum.

Even though the local industry provides for outpatient treatment, it does not provide coverage for children. This and other matters concerning children's welfare are growing issues that face the center. There also is pressure within the center to iron out its administrative problems. This is a difficult task because the director of the hospital complex who directs the clinic also is seen as autocratic and not prone to change.

The mental health clinic provides the usual comprehensive services (inpatient, outpatient, emergency, consultation and education, and partial hospitalization), plus diagnostic services, rehabilitative services, precare, aftercare, training, and research and education. The clinic emphasized outpatient and individual psychotherapy services.

A drug center has been established for the use of the community. This center, which has been open for one year, is staffed by two paid workers and supplemented by volunteers. The center has been under fire since its inception and may soon be closed. It is being criticized for using inadequately trained volunteers; also there has been a civil liberties issue on the right to hold patients and administer medicine to them. There seems to be a growing drug problem in the area, but parents do not want to face this problem. Besides the drug center, there are no other services for children.

Staff and Organization

The whole complex comes under the auspices of the comprehensive community health board. This board is composed of the hospital board and the clinic board, which govern their respective units.

The real power and control seems to be exerted by the director of the hospital unit, whose 25 years of service make him more influential than most center directors. He sees that he has influential people from the community on "his" board. All program operations, from the top down, are reported to him. This means that all staff--30 to 40 people--report directly to him. Although the new hospital and expansion are imminent, the director has not made any plans to change this form of management.

There is good communication among inpatient staff and its director, but communication between the inpatient director and the hospital administrator is minimal. Staff attitude seems one of status quo and complacency. They talk more about patients they have seen than about innovative techniques or programs to provide more services. Part of this may be attributed to the hospital administrator, who fails to delegate responsibility and does not seek input from staff. The consultant feels the management style of the hospital administrator is unworkable.

Current Situation

The biggest problem facing the center now is the inability of any of the staff to exercise flexibility in program development and to provide input to policy level individuals. Staff members seem to have no suggestions for improving the situation in the future.

Two changes have occurred at the center recently: lessening of prescribing drugs for controlling or sedating patients, and reorganization of the psychiatric ward. Outside of this, there has been no innovative delivery system implemented, partially due to the lack of power possessed by the staff. Another reason is the lack of knowledge of other programs throughout the country which are similar to the center's. The staff is not kept up-to-date on mental health issues. There have been no site visits to observe other programs.

There is a divided attitude among staff toward change. Staff interested in change were willing to exchange ideas with the consultant, but they also knew of the difficulties of implementing change because of the hospital administrator. The rest of the staff was quite comfortable and content with the present state of affairs.

Securing funds is not a problem at all in this center. The community oversubscribed the building needs for the new hospital, raising the sum of ten million dollars in one day!

Consultant at the Center

All levels of staff were reached during the two-day visit. Most were willing to talk and they provided the necessary amount of feedback the consultant needed.

The consultant was quite thorough in his interviews. He made suggestions to the hospital administrator for improving the situation, but the administrator's attitude was, "Yes, I'm listening. but I'll do nothing." Clinic staff received the consultant with enthusiasm, but this feeling soon wore down because staff felt that these feelings could go no further. The consultant soon realized the difficulty of working at this center because of the control the administrator has in seeing that all his ideas are implemented.

He made numerous suggestions, but he does not feel that they will be used. He did have the opportunity to observe the whole facility, and he felt that change in this region is doubly difficult because of the conservative community and its conservative director.

Visits by Center Staff

Two members of the staff visited a hospital. This visit concentrated on the inpatient services and the visitors were very impressed with the workability of the inpatient program. All patients are assigned to unit treatment groups, which are operated by nurses, occupational therapists, recreational therapists, etc. The patient's day is fully scheduled in a therapeutic manner for each group. The program is very flexible with the various disciplines comfortable with each other. In spite of the group's orientation, there seems to be a considerable amount of individual attention given to the individual patient. The organization impressed the visitors; they saw the staff were progressive in their approach toward better mental health.

The two differed on which ideas might be effective at the home center. Visitor A liked the staff dress codes, the off-ground activities program, and the inpatient-outpatient therapy groups. Visitor B felt that there should be a looser structure concerning the philosophic aspects of treatment. He stated that his home center always gets "hung up" in terms of what is therapy and who should administer and what to give. The people at the center visited seemed to have that problem solved, even though they could not pinpoint how they solved it. Visitor B was very pessimistic about this problem being solved at his center.

These findings were reported at the regular staff meeting where the staff showed a very positive attitude concerning the visit. All found various aspects of the program could be implemented in various activities at the center, especially since the facility is expanding from a 7-bed to a 28-bed inpatient unit. The staff felt a need for group treatment as opposed to the individual treatment received there. Also the new growth in size calls for group treatment which could be more effective. Each staff member has taken an area of concern to do some research in for presentation back to the group at future staff meetings in order to implement change.

APPENDICES

Appendix 1

Questions Asked In an Effort to Measure the Concepts of Awareness, Willingness, Staff Involvement and Utilization

Concept	Question asked
Awareness	1. To what extent are you interested in knowing more about effective practices elsewhere?
	2. How many professional conferences have you attended in the past year?
	3. How many community mental health centers have you visited in the past year?
	4. Do you know of any research going on now that might be applicable to your work?
Willingness	1. How interested are you in meeting with other staff members to plan new activities for your center?
	2. Approximately what % of the staff at your center do you think are interested in developing new professional skills?
	3. Approximately what % of the staff at your center do you think are generally willing to accept changes in work assignments and responsibilities?
	4. Approximately what % of the staff at your center do you think are generally willing to try new practices?
	5. How willing do you think your center is to try new practices?
Staff Involvement	1. Approximately how often do you informally discuss new practices for your center with other staff members?
	2. Approximately how often do you discuss new practices for your center in staff meetings, committee meetings, or other formal meetings?

Concept	Question asked
Staff Involvement (Cont.)	3. About what % of the staff attend meetings to discuss center programs which are most in need of modification.
	4. About what % of the staff attend meetings to discuss and evaluate possible new practices?
	5. Has the center considered the reactions and satisfaction of the staff to existing and proposed programs.
Utilization	1. Do you have procedures set up to consider changes in practices at your center?
	2. In general, how interested do you feel your center is in utilizing new information and ideas?

Appendix 2

Intercorrelations Between Items on the Original Awareness, Willingness, Staff Involvement and Utilization Scales Pretest

Items	1	2	3	4	T A	1	2	3	4	5	T W	1	2	3	4	5	T SI	1	2	T U
1	1.00	.07	.06	.16	.01	.44	.25	.23	.21	.35	.36	.18	.26	.07	.11	.31	.22	.20	.31	.31
2	.07	1.00	.16	.08	.40	.10	.20	.10	.02	.03	.08	.08	.02	.15	.13	.09	.11	.08	.07	.02
3	.06	.16	1.00	.25	.55	.06	.19	.37	.35	.04	.25	.09	.17	.19	.26	.12	.11	.20	.03	.14
4	.16	.08	.25	1.00	.89	.05	.12	.36	.26	.13	.25	.01	.07	.24	.32	.22	.25	.03	.04	.05
Total	.01	.40	.55	.89	1.00	.01	.05	.33	.28	.06	.20	.02	.02	.28	.36	.14	.24	.14	.05	.13
Awareness																				
1	.44	.10	.06	.05	.01	1.00	.06	.13	.18	.43	.39	.38	.21	.11	.12	.40	.27	.28	.27	.35
2	.25	.20	.19	.12	.05	.06	1.00	.77	.78	.43	.83	.12	.06	.42	.47	.30	.40	.14	.41	.33
3	.23	.10	.37	.36	.33	.13	.77	1.00	.85	.59	.90	.22	.19	.56	.62	.43	.57	.11	.40	.30
4	.21	.02	.35	.26	.28	.18	.78	.85	1.00	.64	.92	.18	.20	.53	.59	.36	.54	.11	.56	.38
5	.35	.03	.04	.13	.06	.43	.43	.59	.64	1.00	.78	.39	.35	.38	.44	.43	.53	.36	.48	.53
Total	.36	.08	.25	.25	.20	.39	.83	.90	.92	.78	1.00	.31	.24	.53	.59	.49	.60	.24	.54	.47
Willingness																				
1	.18	.08	.09	.01	.02	.38	.12	.22	.18	.39	.31	1.00	.57	.31	.32	.36	.66	.29	.22	.34
2	.26	.02	.17	.07	.02	.21	.06	.19	.20	.35	.24	.57	1.00	.23	.27	.19	.60	.25	.23	.31
3	.07	.15	.19	.24	.28	.11	.42	.56	.53	.38	.53	.31	.23	1.00	.88	.35	.85	.16	.33	.29
4	.11	.13	.26	.32	.36	.12	.47	.62	.59	.44	.59	.32	.27	.88	1.00	.43	.87	.25	.35	.38
5	.31	.09	.12	.22	.14	.40	.30	.43	.38	.43	.49	.36	.19	.35	.43	1.00	.54	.19	.18	.24
Total	.22	.11	.11	.25	.24	.27	.40	.57	.54	.53	.60	.66	.60	.85	.87	.54	1.00	.31	.38	.43
Staff Involvement																				
1	.20	.08	.20	.03	.14	.28	.14	.11	.11	.36	.24	.29	.25	.16	.25	.19	.31	1.00	.18	.85
2	.31	.07	.03	.04	.05	.27	.41	.40	.56	.48	.54	.22	.23	.33	.35	.18	.38	.18	1.00	.67
Total	.31	.02	.14	.05	.13	.35	.33	.30	.38	.53	.47	.34	.31	.29	.38	.24	.43	.85	.67	1.00
Utilization																				

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Appendix 3

Intercorrelations Between Items on the Original Awareness, Willingness, Staff Involvement and Utilization Scales Immediate Posttest

Items	1	2	3	4	T A	1	2	3	4	5	T W	1	2	3	4	5	T SI	1	2	T U
1	1.00	.24	.18	.11	.33	.45	.09	.06	.07	.01	.04	.04	.14	.16	.16	.09	.16	.10	.05	.04
2	.24	1.00	.04	.17	.10	.10	.26	.29	.46	.30	.39	.01	.22	.29	.29	.17	.26	.13	.38	.28
3	.18	.04	1.00	.16	.42	.29	.04	.01	.09	.11	.11	.21	.20	.26	.25	.26	.00	.02	.05	.04
4	.11	.17	.16	1.00	.89	.00	.13	.11	.02	.08	.09	.21	.11	.00	.15	.02	.05	.13	.18	.18
Total	.33	.10	.42	.89	1.00	.22	.05	.01	.16	.05	.08	.22	.17	.02	.15	.10	.08	.05	.04	.05
Awareness																				
1	.45	.10	.29	.00	.22	1.00	.16	.14	.09	.18	.32	.02	.17	.04	.06	.13	.04	.13	.06	.06
2	.09	.26	.04	.13	.05	.16	1.00	.57	.51	.55	.79	.26	.46	.34	.49	.44	.53	.22	.44	.37
3	.06	.29	.01	.11	.01	.14	.57	1.00	.78	.68	.89	.29	.24	.54	.59	.35	.56	.07	.36	.23
4	.07	.46	.09	.02	.16	.09	.51	.78	1.00	.52	.82	.24	.20	.52	.53	.30	.50	.09	.41	.27
5	.01	.30	.11	.08	.05	.18	.55	.68	.52	1.00	.81	.25	.52	.45	.45	.56	.58	.33	.59	.53
Total	.04	.39	.11	.09	.08	.32	.79	.89	.82	.81	1.00	.30	.44	.52	.58	.49	.63	.23	.51	.41
Willingness																				
1	.04	.01	.21	.21	.22	.02	.26	.29	.24	.25	.30	1.00	.54	.08	.29	.29	.62	.18	.39	.32
2	.14	.22	.20	.11	.17	.17	.46	.24	.20	.52	.44	.54	1.00	.30	.40	.49	.73	.25	.43	.39
3	.16	.29	.26	.00	.02	.04	.34	.54	.52	.45	.52	.08	.30	1.00	.81	.52	.75	.13	.32	.25
4	.16	.29	.25	.15	.15	.06	.49	.59	.53	.45	.58	.29	.40	.81	1.00	.60	.85	.17	.48	.36
5	.09	.17	.26	.02	.10	.13	.44	.35	.30	.56	.49	.29	.49	.52	.60	1.00	.73	.34	.50	.48
Total	.16	.26	.00	.05	.08	.04	.53	.56	.50	.58	.63	.62	.73	.75	.85	.73	1.00	.27	.57	.47
Staff Involvement																				
1	.10	.13	.02	13	.05	.13	.22	.07	.09	.33	.23	.18	.25	.13	.17	.34	.27	1.00	.43	.89
2	.05	.38	.05	.18	.04	.06	.44	.36	.41	.59	.51	.39	.43	.32	.48	.50	.57	.43	1.00	.80
Total	.04	.28	.04	.18	.05	.06	.37	.23	.27	.53	.41	.32	.39	.25	.36	.48	.47	.89	.80	1.00
Utilization																				

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Appendix 4

Intercorrelations Between Items on the Original Awareness, Willingness, Staff Involvement and Utilization Scales
Delayed Posttest

					T						T						T			T
Items	1	2	3	4	A	1	2	3	4	5	W	1	2	3	4	5	SI	1	2	U
1	1.00	.25	.20	.32	.56	.45	.13	.25	.10	.18	.02	.13	.08	.16	.13	.16	.18	.09	.24	.18
2	.25	1.00	.45	.20	.56	.22	.10	.04	.13	.12	.17	.15	.10	.02	.10	.02	.02	.00	.20	.09
3	.20	.45	1.00	.15	.51	.34	.03	.14	.04	.10	.06	.23	.16	.01	.03	.01	.12	.07	.08	.01
4	.32	.20	.15	1.00	.86	.03	.17	.35	.21	.13	.16	.01	.01	.15	.05	.06	.08	.15	.06	.13
Total	.56	.56	.51	.86	1.00	.26	.11	.33	.14	.19	.05	.01	.01	.08	.04	.00	.04	.11	.16	.15
Awareness																				
1	.45	.22	.34	.03	.26	1.00	.14	.02	.09	.05	.19	.20	.07	.18	.21	.03	.07	.04	.11	.02
2	.13	.10	.03	.17	.11	.14	1.00	.63	.71	.57	.81	.37	.47	.52	.63	.42	.67	.22	.51	.39
3	.25	.04	.14	.35	.33	.02	.63	1.00	.81	.42	.83	.29	.27	.40	.49	.28	.49	.15	.42	.30
4	.10	.13	.04	.21	.14	.09	.71	.81	1.00	.59	.88	.28	.36	.53	.66	.44	.64	.29	.57	.46
5	.18	.12	.10	.13	.19	.15	.57	.42	.59	1.00	.77	.35	.57	.44	.50	.33	.60	.40	.86	.68
Total	.02	.17	.06	.16	.05	.19	.81	.83	.88	.77	1.00	.42	.51	.51	.61	.42	.68	.30	.71	.54
Willingness																				
1	.13	.15	.23	.01	.01	.20	.37	.29	.28	.35	.42	1.00	.61	.15	.19	.23	.57	.07	.26	.17
2	.08	.10	.16	.01	.01	.07	.47	.27	.36	.57	.51	.61	1.00	.31	.33	.34	.67	.30	.44	.41
3	.16	.02	.01	.15	.08	.18	.52	.40	.53	.44	.51	.15	.31	1.00	.91	.57	.85	.35	.35	.41
4	.13	.10	.03	.05	.04	.21	.63	.49	.66	.50	.61	.19	.33	.91	1.00	.53	.86	.38	.47	.49
5	.16	.02	.01	.06	.00	.03	.42	.28	.44	.33	.42	.23	.34	.57	.52	1.00	.65	.32	.32	.37
Total	.18	.02	.12	.08	.04	.07	.67	.49	.64	.60	.68	.57	.67	.85	.86	.65	1.00	.38	.51	.51
Staff Involvement																				
1	.09	.00	.07	.15	.11	.04	.22	.15	.29	.40	.30	.07	.30	.35	.38	.32	.38	1.00	.45	.91
2	.24	.20	.08	.06	.16	.11	.51	.42	.57	.86	.71	.26	.44	.35	.48	.32	.51	.45	1.00	.79
Total	.18	.09	.01	.13	.15	.02	.39	.30	.46	.68	.54	.17	.41	.41	.49	.37	.51	.91	.79	1.00
Utilization																				

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Appendix 5

Intercorrelations Between Items on the Revised Scales Pretest

Items	1	2	3	4	5	6[a]	7[b]	T W	1	2	3	4	5	T SI	1[c]	2[d]	3[e]	4[f]
1	1.00	.06	.13	.18	.43	.27	.44	.42	.38	.21	.11	.12	.40	.27	.28	.10	.06	.05
2	.06	1.00	.77	.78	.43	.41	.25	.80	.12	.06	.42	.47	.30	.40	.14	.20	.19	.12
3	.13	.77	1.00	.85	.59	.40	.23	.85	.22	.19	.56	.62	.43	.57	.11	.10	.37	.36
4	.18	.78	.85	1.00	.64	.56	.21	.90	.18	.20	.53	.59	.38	.54	.11	.02	.35	.26
5	.43	.43	.59	.64	1.00	.48	.35	.78	.39	.35	.38	.44	.43	.53	.36	.03	.04	.13
6	.27	.41	.40	.56	.48	1.00	.31	.70	.22	.23	.33	.35	.18	.38	.18	.07	.03	.04
7	.44	.25	.23	.21	.35	.31	1.00	.46	.18	.26	.07	.11	.31	.22	.19	.07	.06	.16
Total	.42	.80	.85	.90	.78	.70	.46	1.00	.32	.28	.52	.58	.47	.60	.26	.04	.20	.21
Willingness																		
1	.38	.12	.22	.18	.39	.22	.18	.32	1.00	.57	.31	.32	.36	.66	.29	.08	.09	.01
2	.21	.06	.19	.20	.35	.23	.26	.28	.57	1.00	.23	.27	.19	.60	.25	.02	.17	.07
3	.11	.42	.56	.53	.38	.33	.07	.52	.31	.23	1.00	.88	.35	.85	.16	.15	.19	.24
4	.12	.47	.62	.59	.44	.35	.11	.58	.32	.27	.88	1.00	.43	.87	.25	.13	.26	.32
5	.40	.30	.43	.38	.43	.18	.31	.47	.36	.19	.35	.43	1.00	.54	.19	.09	.12	.22
Total	.27	.40	.57	.54	.53	.38	.22	.60	.66	.60	.85	.87	.54	1.00	.31	.11	.11	.25
Staff Involvement																		
1	.28	.14	.11	.11	.36	.18	.19	.26	.29	.25	.16	.25	.19	.31	1.00	.08	.20	.03
2	.10	.20	.10	.02	.03	.07	.07	.04	.08	.02	.14	.13	.09	.11	.08	1.00	.16	.08
3	.06	.19	.37	.35	.04	.03	.06	.20	.09	.17	.19	.26	.12	.11	.20	.16	1.00	.25
4	.05	.12	.36	.26	.13	.04	.16	.21	.01	.07	.24	.32	.22	.25	.03	.08	.25	1.00

[a] Originally Item 2 of Utilization
[b] Originally Item 1 of Awareness
[c] Originally Item 1 of Utilization
[d] Originally Item 2 of Awareness
[e] Originally Item 3 of Awareness
[f] Originally Item 4 of Awareness

Appendix 6

Intercorrelations Between Items on the Revised Scales Immediate Posttest

Items	1	2	3	4	5	6^a	7^b	T W	1	2	3	4	5	T SI	1^c	2^d	3^e	4^f
1	1.00	.16	.14	.09	.18	.06	.45	.32	.02	.17	.04	.06	.13	.04	.13	.10	.29	.00
2	.16	1.00	.57	.51	.55	.44	.09	.75	.26	.46	.34	.49	.44	.53	.22	.26	.04	.13
3	.14	.57	1.00	.78	.68	.36	.06	.84	.29	.24	.54	.59	.35	.56	.07	.29	.01	.11
4	.09	.51	.78	1.00	.52	.41	.07	.77	.24	.20	.52	.53	.30	.50	.09	.46	.09	.02
5	.18	.55	.68	.52	1.00	.59	.01	.83	.25	.52	.45	.45	.56	.58	.33	.30	.11	.08
6	.06	.44	.36	.41	.59	1.00	.05	.67	.39	.43	.32	.48	.50	.57	.43	.38	.05	.18
7	.45	.09	.06	.07	.01	.05	1.00	.18	.04	.14	.16	.16	.09	.16	.09	.24	.18	.11
Total	.32	.75	.84	.77	.83	.67	.18	1.00	.34	.45	.49	.58	.52	.64	.31	.38	.13	.10
Willingness																		
1	.02	.26	.29	.24	.25	.39	.04	.34	1.00	.54	.08	.29	.29	.62	.18	.01	.21	.21
2	.17	.46	.24	.20	.52	.43	.14	.45	.54	1.00	.30	.40	.49	.73	.25	.22	.20	.11
3	.04	.34	.54	.52	.45	.32	.16	.49	.08	.30	1.00	.81	.52	.75	.13	.29	.26	.00
4	.06	.49	.59	.53	.45	.48	.16	.58	.29	.40	.81	1.00	.60	.85	.17	.29	.25	.15
5	.13	.44	.35	.30	.56	.50	.09	.52	.29	.49	.52	.60	1.00	.73	.34	.17	.26	.02
Total	.04	.53	.56	.50	.58	.57	.16	.64	.62	.73	.75	.85	.73	1.00	.27	.26	.00	.05
Staff Involvement																		
1	.13	.22	.07	.09	.33	.43	.09	.31	.18	.25	.13	.17	.34	.27	1.00	.13	.02	.13
2	.10	.26	.29	.46	.30	.38	.24	.38	.01	.22	.29	.29	.17	.26	.13	1.00	.04	.17
3	.29	.04	.01	.09	.11	.05	.18	.13	.21	.20	.26	.25	.26	.00	.02	.04	1.00	.16
4	.00	.13	.11	.02	.08	.18	.11	.10	.21	.11	.00	.15	.02	.05	.13	.17	.16	1.00

[a] Originally Item 2 of Utilization
[b] Originally Item 1 of Awareness
[c] Originally Item 1 of Utilization
[d] Originally Item 2 of Awareness
[e] Originally Item 3 of Awareness
[f] Originally Item 4 of Awareness

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Appendix 7

Intercorrelations Between Items on the Revised Scales Delayed Posttest

Items	1	2	3	4	5	6^{a}	7^{b}	T W	1	2	3	4	5	T SI	1^{c}	2^{d}	3^{e}	4^{f}
1	1.00	.14	.02	.09	.05	.11	.45	.25	.20	.07	.18	.21	.03	.07	.04	.22	.34	.03
2	.14	1.00	.63	.71	.57	.51	.13	.74	.37	.47	.52	.63	.42	.67	.22	.10	.03	.17
3	.02	.63	1.00	.81	.42	.41	.25	.72	.29	.27	.40	.49	.28	.49	.15	.04	.14	.35
4	.09	.71	.81	1.00	.59	.57	.10	.82	.28	.36	.53	.66	.44	.64	.29	.13	.04	.21
5	.05	.57	.42	.59	1.00	.86	.18	.84	.35	.57	.44	.50	.33	.60	.40	.12	.10	.13
6	.11	.51	.41	.57	.86	1.00	.24	.83	.26	.44	.35	.48	.32	.51	.45	.20	.08	.06
7	.45	.13	.25	.10	.18	.24	1.00	.24	.13	.08	.16	.13	.16	.18	.09	.25	.20	.32
Total	.25	.74	.72	.82	.84	.83	.24	1.00	.37	.49	.46	.58	.38	.63	.36	.22	.10	.06
Willingness																		
1	.20	.37	.29	.28	.35	.26	.13	.37	1.00	.61	.15	.19	.23	.57	.07	.15	.23	.01
2	.07	.47	.27	.36	.57	.44	.08	.49	.61	1.00	.31	.33	.34	.67	.30	.10	.16	.01
3	.18	.52	.40	.53	.44	.35	.16	.46	.15	.31	1.00	.91	.57	.85	.35	.02	.01	.15
4	.21	.63	.49	.66	.50	.48	.13	.58	.19	.33	.91	1.00	.52	.86	.38	.10	.03	.05
5	.03	.42	.28	.44	.33	.32	.16	.38	.23	.34	.57	.52	1.00	.65	.32	.02	.01	.06
Total	.07	.67	.49	.64	.60	.51	.18	.63	.57	.67	.85	.86	.65	1.00	.38	.02	.12	.08
Staff Involvement																		
1	.04	.22	.15	.29	.40	.45	.09	.36	.07	.30	.35	.38	.32	.38	1.00	.00	.07	.15
2	.22	.10	.04	.13	.12	.20	.25	.22	.15	.10	.02	.10	.02	.02	.00	1.00	.45	.20
3	.34	.03	.14	.04	.10	.08	.20	.10	.23	.16	.01	.03	.01	.12	.07	.45	1.00	.15
4	.03	.17	.35	.21	.13	.06	.32	.06	.01	.01	.15	.05	.06	.08	.15	.20	.15	1.00

[a] Originally Item 2 of Utilization
[b] Originally Item 1 of Awareness
[c] Originally Item 1 of Utilization
[d] Originally Item 2 of Awareness
[e] Originally Item 3 of Awareness
[f] Originally Item 4 of Awareness

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Appendix 8

Descriptive Statistics for Willingness Scale

		Mean	Standard Deviation	N
Q1	A	27.75	2.43	15
	B	28.79	2.34	14
	C	28.22	2.92	16
	D	28.03	2.46	15
Q2	A	27.87	2.19	15
	B	28.00	1.54	14
	C	28.21	2.92	16
Q3	A	27.48	1.92	15
	B	27.74	1.73	14
	C	27.58	3.50	16
	D	27.95	1.63	15

Appendix 9

Analysis of Variance on Willingness Scale at Q1

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between Groups	8.23	3	2.74	
Within groups	366.83	56	6.55	.42
Total	375.06	59		

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Appendix 10

Analysis of Variance on Willingness Scale at Q2

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	0.94	2	.47	
Within groups	225.45	42	5.37	.09
Total	226.39	44		

Appendix 11

Analysis of Variance on Willingness Scale at Q3

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	1.93	3	.64	
Within groups	311.70	56	5.57	.12
Total	313.63	59		

Appendix 12

Descriptive Statistics for Involvement Scale

		Mean	Standard Deviation	N
Q1	A	17.81	2.13	15
	B	18.29	2.74	14
	C	17.60	2.79	16
	D	16.67	2.03	15
Q2	A	16.53	2.30	15
	B	16.50	1.91	14
	C	17.27	2.08	16
Q3	A	16.81	2.39	15
	B	16.41	2.05	14
	C	17.26	2.56	16
	D	17.28	2.81	15

Appendix 13

Analysis of Variance on Involvement Scale at Q1

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	20.21	3	6.74	
Within groups	334.99	56	5.98	1.13
Total	355.20	59		

Appendix 14

Analysis of Variance on Involvement Scale at Q2

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	5.82	2	2.91	
Within groups	186.17	42	4.43	.66
Total	191.99	44		

Appendix 15

Analysis of Variance on Involvement Scale at Q3

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	7.54	3	2.51	
Within Groups	343.47	56	6.13	.41
Total	351.00	59		

Appendix 16

Descriptive Statistics for Number of Professional Conferences Attended

		Mean	Standard Deviation	N
Q1	A	3.04	1.11	15
	B	3.34	1.70	14
	C	3.03	2.11	16
	D	2.48	1.19	15
Q2	A	2.61	.78	15
	B	2.64	.71	14
	C	3.13	1.91	16
Q3	A	2.77	.79	15
	B	3.31	1.41	14
	C	2.74	1.50	16
	D	3.49	1.78	15

Appendix 17

Analysis of Variance on Attendance at Professional Conferences at Q1

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	5.71	3	1.90	
Within groups	141.66	56	2.53	.75
Total	147.37	59		

Appendix 18

Analysis of Variance on Attendance at Professional Conferences at Q2

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	2.62	2	1.31	
Within groups	69.47	42	1.65	.79
Total	72.09	44		

Appendix 19

Analysis of Variance on Attendance at Professional Conferences at Q3

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	6.52	3	2.17	
Within groups	112.45	56	2.01	1.08
Total	118.97	59		

Appendix 20

Descriptive Statistics for Number of Mental Health Centers Visited

		Mean	Standard Deviation	N
Q1	A	2.00	1.77	15
	B	2.32	2.26	14
	C	1.54	.95	16
	D	1.61	1.00	15
Q2	A	1.51	1.11	15
	B	1.87	.84	14
	C	1.62	.89	16
Q3	A	1.96	1.59	15
	B	1.97	.69	14
	C	1.78	1.00	16
	D	2.50	1.66	15

Appendix 21

Analysis of Variance on Community Mental Health Centers Visited at Q1

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	5.92	3	1.97	
Within groups	137.38	56	2.45	.80
Total	143.30	59		

Appendix 22

Analysis of Variance on Community Mental Health Centers Visited at Q2

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	1.00	2	.50	
Within groups	38.13	42	.91	.55
Total	39.13	44		

Appendix 23

Analysis of Variance on Community Mental Health Centers Visited at Q3

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	4.41	3	1.47	
Within groups	94.86	56	1.69	.87
Total	99.27	59		

Appendix 24

Descriptive Statistics for Procedures for Change

		Mean	Standard Deviation	N
Q1	A	2.48	.49	15
	B	2.46	.46	14
	C	2.44	.41	16
	D	2.36	.62	15
Q2	A	2.48	.47	15
	B	2.45	.49	14
	C	2.61	.43	16
Q3	A	2.40	.46	15
	B	2.66	.43	14
	C	2.65	.46	16
	D	2.74	.44	15

Appendix 25

Analysis of Variance on Procedures for Change at Q1

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	0.13	3	.04	
Within groups	13.94	56	.25	.18
Total	14.07	59		

Appendix 26

Analysis of Variance on Procedures of Change at Q2

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	.24	2	.12	
Within groups	9.08	42	.22	.56
Total	9.32	44		

Appendix 27

Analysis of Variance on Procedures of Change at Q3

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	F
Between groups	1.00	3	.33	
Within groups	11.25	56	.20	1.65
Total	12.25	59		

Appendix 28

QD

Treatment Group

# Innovations	A	B	C	D	Total
Few	6	4	2	8	20
Some	4	5	8	3	20
Many	5	5	6	4	20
	15	14	16	15	60

$X^2 = 6.8649$, df = 6

Appendix 29

Q3

Treatment Group

# Innovations	A	B	C	D	Total
Few	5	0	6	4	15
Some	6	6	7	8	27
Many	4	8	3	3	18
	15	14	16	15	60

$X^2 = 9.9945$, df = 6

Appendix 30

QD

Size

		Small	Medium	Large	Total
# Innovations	Few	8	7	4	19
	Some	7	10	3	20
	Many	6	5	10	21
		21	22	17	60

X^2 = 6.9646, df = 4

Appendix 31

Q3

Size

		Small	Medium	Large	Total
# Innovations	Few	5	7	4	16
	Some	11	7	9	27
	Many	5	8	4	17
		21	22	17	60

X^2 = 2.4972, df = 4

Appendix 32

QD

Age (Years)

		Less than 2	2-4	5 or more	Total
# Innovations	Few	5	13	2	20
	Some	9	5	6	20
	Many	5	5	10	20
		19	23	18	60

$X^2 = 11.5897$, df = 4

Appendix 33

Q3

Age (Years)

		Less than 2	2-4	5 or more	Total
# Innovations	Few	3	7	5	15
	Some	11	9	7	27
	Many	5	7	6	18
		19	23	18	60

$X^2 = 2.1691$, df = 4

Appendix 34

QD

Region

		East	South	Midwest	West	Total
# Innovations	Few	5	4	8	3	20
	Some	5	4	7	4	20
	Many	6	4	3	7	20
		16	12	18	14	60

$X^2 = 4.3039$, df = 6

Appendix 35

Q3

Region

		East	South	Midwest	West	Total
# Innovations	Few	5	2	4	4	15
	Some	7	6	8	6	27
	Many	4	4	6	4	18
		16	12	18	14	60

$X^2 = 1.0515$, df = 6

Appendix 36

QD

Ownership

		Public	Private	Total
# Innovations	Few	10	10	20
	Some	11	9	20
	Many	5	15	20
		26	34	60

$X^2 = 4.2048$, df = 2

Appendix 37

Q3

Control

		Public	Private	Total
# Innovations	Few	8	7	15
	Some	13	14	27
	Many	5	13	18
		26	34	60

$X^2 = 2.6393$, df = 2

Appendix 38

Pre-treatment Data

Number of Innovations

		Few (0-4)	Some (5-8)	Many (9+)
Treatment Group	A & B	10	9	10
	C & D	10	11	9

$X^2 = .23$, df = 2

Appendix 39

Post-treatment Data

Number of Innovations

		Few (0-4)	Some (5-8)	Many (9+)
Treatment Group	A & B	5	12	12
	C & D	9	15	6

$X^2 = 3.55$, df = 2

APPENDIX A - Questionnaire to Directors

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AMERICAN INSTITUTES FOR RESEARCH

SOCIAL AND EDUCATIONAL RESEARCH PROGRAM

INFORMATION ON COMMUNITY MENTAL HEALTH CENTERS

Center ____________________

Name of person providing information, if other than director ____________________

Director ____________________

1. When was your center opened? ____________________ Month / Year

2. About how many full-time equivalent personnel are employed at the center? __________

3. Approximately how many individuals are served each year by your center? __________

4. Which group of clients does your center primarily serve?
   - Low income . . . . ○
   - Lower-middle . . . . . . ○
   - Middle income and above . . ○

5. What is the total gross annual budget for the center?
   - Less than $250,000 . . . . ○
   - $250,000-500,000 . . . . ○
   - $500,000-1 million . . . . ○
   - $1 million-2 million . . . . ○
   - Over $2 million . . . . . . ○

6. How many new practices have been introduced during the last two years, or since your center opened if it has not been in operation for two years? __________

7. How many new practices are you currently planning to implement? __________

8. Following is a checklist outlining some areas of concern in which you might like to receive ideas from other centers. Please rank these areas by placing a 1 before the area of primary concern, a 2 before the second most important area, a 3 before the third most important area, and so on for as many areas as are of interest to you.

   - _____ Continuity of patient care
   - _____ Inpatient treatment
   - _____ Outpatient treatment
   - _____ Special treatment programs
   - _____ Crisis services
   - _____ Rehabilitation services
   - _____ Community consultation and education
   - _____ Center organization and administration
   - _____ Staff development
   - _____ Program planning
   - _____ Program evaluation
   - _____ Relationships with other service agencies
   - _____ Promotion and financial support
   - _____ Other ____________________ ____________________

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9. What are the effective practices or techniques that are new at your center and intended to lead to more effective achievement of aims? List only those activities which have been introduced during the last two years. We would appreciate knowing the title (or a brief descriptive phrase) and the person to contact for more information. If you need more room, please add another page.

Title of Practice	Name of Contact Person

10. Would your center be willing to explain these practices further to visitors?

Yes . . . . . ○ No . . . . . ○ Maybe . . . . . ○

APPENDIX B - Pre-treatment Questionnaire (Q1) BEST COPY AVAILABLE

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SOCIAL AND EDUCATIONAL RESEARCH PROGRAM

Evaluation of NIMH-AIR Project
Preliminary Questionnaire

Center: ______________________ Name: ______________________

Note: In this questionnaire the term practices refers to programs, activities, or techniques of community mental health centers. This includes activities in the areas of patient care, administration, and program planning and evaluation.

Staff refers to all levels of professional staff and also non-professional mental health workers.

1. To what extent are you interested in knowing more about effective practices elsewhere? (Circle one of the responses below.)

Not at all Interested	A little Interested	Somewhat Interested	Quite Interested	Very Interested

2. Which of these sources do you find most useful in learning about practices in mental health? (Mark up to three.)

○ Abstracts and brief descriptions
○ Journal articles
○ Books
○ Informal contact with colleagues at your center
○ Formal meetings at your center
○ Interaction with people outside the center
○ Other training, such as course work
○ Special consultants at your center
○ Professional conferences
○ Visits to other centers
○ Other (Specify) ______________________

____

3. How interested are you in meeting with other staff members to plan new activities for your center? (Circle one of the responses below.)

Not at all Interested	A little Interested	Somewhat Interested	Quite Interested	Very Interested

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4. How many professional conferences have you attended in the past year? ____________

5. How many community mental health centers have you visited in the past year? ____________

6. Do you know about any practices being used at community mental health centers which you would like to try at your center? If so, please list them.

a. ______________________________

b. ______________________________

c. ______________________________

7. Do you know of any research going on now that might be applicable to your work? If so, please list the topics.

a. ______________________________

b. ______________________________

c. ______________________________

8. Approximately how often do you informally discuss new practices for your center with other staff members?

○ Several times each week
○ Once a week
○ Once every two or three weeks
○ Once a month
○ Less than once a month

9. Approximately how often do you discuss new practices for your center in staff meetings, committee meetings, or other formal meetings?

○ Several times each week
○ Once a week
○ Once every two or three weeks
○ Once every two or three months
○ Less than every two or three months

The next group of questions ask for your opinion of certain characteristics of the center as a whole or of the staff at your center.

10. About what percent of the staff attend meetings to discuss center programs which are most in need of modification?

○ Very few, less than 10%
○ A few, 10% to 30%
○ Some, 30% to 70%
○ Most, 70% to 90%
○ Almost all, over 90%

11. About what percent of the staff attend meetings to discuss and evaluate possible new practices?

○ Very few, less than 10%
○ A few, 10% to 30%
○ Some, 30% to 70%
○ Most, 70% to 90%
○ Almost all, over 90%

12. Approximately what percent of the staff at your center do you think are interested in developing new professional skills?

○ Very few, less than 10%
○ A few, 10% to 30%
○ Some, 30% to 70%
○ Most, 70% to 90%
○ Almost all, over 90%

13. Approximately what percent of the staff at your center do you think are generally willing to accept changes in work assignments and responsibilities?

○ Very few, less than 10%
○ A few, 10% to 30%
○ Some, 30% to 70%
○ Most, 70% to 90%
○ Almost all, over 90%

14. Approximately what percent of the staff at your center do you think are generally willing to try new practices?

○ Very few, less than 10%
○ A few, 10% to 30%
○ Some, 30% to 70%
○ Most, 70% to 90%
○ Almost all, over 90%

15. How willing do you think your center is to try new practices? (Circle one of the response below.)

Unwilling	Reluctant	Willing	Quite Willing	Enthusiastic

16. Has the center considered the reactions and satisfaction of the staff to existing and proposed programs?

○ Yes ○ No ○ I don't know

If yes, what methods are used to assess staff opinion?

17. Do you have procedures set up to consider changes in practices at your center?

○ Yes ○ No ○ I don't know

If yes, please describe:

18. To what extent are these procedures used?

Rarely	Occasionally	About half the time	Usually	Almost always

19. In general, how interested do you feel your center is in utilizing new information and ideas?

APPENDIX C - Post-treatment (short-term) Questionnaire (Q2)

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Evaluation of NIMH-AIR Project

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Center: ____________________ Name: ____________________

Note: In this questionnaire the term practices refers to programs, activities, or techniques of community mental health centers. This includes activities in the areas of patient care, administration, and program planning and evaluation.

Staff refers to all levels of professional staff and also non-professional mental health workers.

1. To what extent are you interested in knowing more about effective practices elsewhere? (Circle one of the responses below.)

Not at all Interested	A little Interested	Somewhat Interested	Quite Interested	Very Interested

2. How interested are you in meeting with other staff members to plan new activities for your center? (Circle one of the responses below.)

Not at all Interested	A little Interested	Somewhat Interested	Quite Interested	Very Interested

3. How willing do you think your center is to try new practices? (Circle one of the responses below.)

Unwilling	Reluctant	Willing	Quite Willing	Enthusiastic

4. Which of these sources do you find most useful in learning about practices in mental health? (Mark up to three.)

- ○ Abstracts and brief descriptions
- ○ Journal articles
- ○ Books
- ○ Informal contact with colleagues at your center
- ○ Formal meetings at your center
- ○ Interaction with people outside the center
- ○ Other training, such as course work
- ○ Special consultants at your center
- ○ Professional conferences
- ○ Visits to other centers
- ○ Other (Specify) ____________________

____

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The next group of questions asks for your opinion of certain characteristics of the center as a whole or of the staff at your center.

5. About what percent of the staff attend meetings to discuss center programs which are most in need of modification?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

6. About what percent of the staff attend meetings to discuss and evaluate possible new practices?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

7. Approximately what percent of the staff at your center do you think are interested in developing new professional skills?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

8. Approximately what percent of the staff at your center do you think are generally willing to accept changes in work assignments and responsibilities?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

9. Approximately what percent of the staff at your center do you think are generally willing to try new practices?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

10. Approximately how often do you informally discuss new practices for your center with other staff members?
    - ○ Several times each week
    - ○ Once a week
    - ○ Once every two or three weeks
    - ○ Once a month
    - ○ Less than once a month

11. Approximately how often do you discuss new practices for your center in staff meetings, committee meetings, or other formal meetings?
    - ○ Several times each week
    - ○ Once a week
    - ○ Once every two or three weeks
    - ○ Once every two or three months
    - ○ Less than every two or three months

12. Has the center considered the reactions and satisfaction of the staff to existing and proposed programs?
    - ○ Yes
    - ○ No
    - ○ I don't know

    If yes, what methods are used to assess staff opinion?

    ____

    ____

13. How many professional conferences have you attended in the past year? ________

14. How many community mental health centers have you visited in the past year? ________

15. List any practices which have been considered at your center during the past year. Please indicate whether they have been implemented or are under discussion only.

	Being Implemented	Under Discussion Only
a. ________	○	○
b. ________	○	○
c. ________	○	○
d. ________	○	○
e. ________	○	○
f. ________	○	○
g. ________	○	○
h. ________	○	○

16. Do you know of any research going on now that might be applicable to your work? If so, please list the topics.

a. ________

b. ________

c. ________

17. Do you have procedures set up to consider changes in practices at your center?

○ Yes ○ No ○ I don't know

If yes, please describe:

18. To what extent are these procedures used?

Rarely	Occasionally	About half the time	Usually	Almost always

19. In general, how interested do you feel your center is in utilizing new information and ideas?

20. In your opinion, how useful was the consultant's visit to your center?

Not at all Useful	Somewhat Useful	Useful	Very Useful	Extremely Useful

21. What aspects of the consultant's visit were most or least useful? Please be specific.

22. In your opinion, how useful is the Source Book of Programs?

Not at all Useful	Somewhat Useful	Useful	Very Useful	Extremely Useful

23. What features of the Source Book of Programs are most or least useful? Please be specific.

24. In your opinion, how useful is the booklet Planning for Change?

Not at all Useful	Somewhat Useful	Useful	Very Useful	Extremely Useful

25. What features of the booklet Planning for Change are most or least useful? Please be specific.

APPENDIX D - Post-treatment (long-term) Questionnaire (Q3)

AMERICAN INSTITUTES FOR RESEARCH

SOCIAL AND EDUCATIONAL RESEARCH PROGRAM

FINAL EVALUATION OF NIMH-AIR PROJECT

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Center: ______________________ Name: ______________________

Note: In this questionnaire the term practices refers to programs, activities, or techniques of community mental health centers. This includes activities in the areas of patient care, administration, and program planning and evaluation. Staff refers to all levels of professional staff and also non-professional mental health workers.

1. To what extent are you interested in knowing more about effective practices elsewhere? (Circle one of the responses below.)

Not at all Interested	A little Interested	Somewhat Interested	Quite Interested	Very Interested

2. How interested are you in meeting with other staff members to plan new activities for your center? (Circle one of the responses below.)

Not at all Interested	A little Interested	Somewhat Interested	Quite Interested	Very Interested

3. How willing do you think your center is to try new practices? (Circle one of the responses below.)

Unwilling	Reluctant	Willing	Quite Willing	Enthusiastic

4. In general, how interested do you feel your center is in utilizing new information and ideas? (Circle one of the responses below.)

Not at all Interested	A little Interested	Somewhat Interested	Quite Interested	Very Interested

5. How many new practices have been introduced at your center since January, 1973? ________

6. How many new practices is your center planning to implement? ________

7. How many professional conferences have you attended in the past year? ________

8. How many community mental health centers have you visited in the past year? ________

9. Do you know of any research going on now that might be applicable to your work?
○ Yes ○ No
If Yes, please list the topics.

The next group of questions asks for your opinion of certain characteristics of the cente
as a whole or of the staff at your center.

10. About what percent of the staff attend meetings to discuss center programs which are most in need of modification?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

11. About what percent of the staff attend meetings to discuss and evaluate possible new practices?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

12. Approximately what percent of the staff at your center do you think are interested in developing new professional skills?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

13. Approximately what percent of the staff at your center do you think are generally willing to accept changes in work assignments and responsibilities?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

14. Approximately what percent of the staff at your center do you think are generally willing to try new practices?
   - ○ Very few, less than 10%
   - ○ A few, 10% to 30%
   - ○ Some, 30% to 70%
   - ○ Most, 70% to 90%
   - ○ Almost all, over 90%

15. Approximately how often do you informally discuss new practices for your center with other staff members?
   - ○ Less than once a month
   - ○ Once a month
   - ○ Once every two or three weeks
   - ○ Once a week
   - ○ Several times each week

16. Approximately how often do you discuss new practices for your center in staff meeting committee meetings, or other formal meetings?
   - ○ Less than every two or three months
   - ○ Once every two or three months
   - ○ Once every two or three weeks
   - ○ Once a week
   - ○ Several times each week

* * * * * *

17. Has the center considered the reactions and satisfaction of the staff to existing and proposed programs?
   ○ Yes ○ No ○ I don't know

18. Do you have procedures set up to consider changes in practices at your center?
   ○ Yes ○ No ○ I don't know

19. Have the procedures changed during the past few months?
   ○ Yes ○ No ○ I don't know

   If Yes, how?

20. Has there been any evaluation of new practices at your center since January, 1973?
○ Yes ○ No ○ I don't know

If Yes, what methods are used for evaluating new programs?

21. What approaches have been the most useful in considering innovations at your center? Please rank the following from 1 = Least Useful to 4 = Most Useful.

____Consultant
____Source Book of Programs
____Planning for Change
____Site visits to other centers

SITE VISITS

22. Which one of the following procedures was used in selecting staff to make site visits to other centers?

○ Staff meetings
○ Informal discussion
○ Decided by director
○ Decided by administrative staff
○ Written requests
○ Other ____________________

23. Were you personally a site visitor?
○ Yes If YES, please respond to 23a and 23b.
○ No. If NO, please respond to 23c.

23a. Why did you select the site you visited?

23b. How did you first learn about the program at the site you visited? (Mark only on answer.)

○ Director or other staff member at your center
○ Source Book of Programs
○ Read about it somewhere else
○ Someone outside your center told you
○ Other ____________________

23c. If No, what did you learn about the program from the person who made the visit?

24. To what extent has the site visit to other centers been useful in considering new practices at your center? (Circle one of the responses below.)

Not at all Useful	Slightly Useful	Moderately Useful	Very Useful	Extremely Useful

25. To what extent were the innovations observed at other centers compatible with the needs of your center? (Circle one of the responses below.)

Not at all Compatible	Slightly Compatible	Moderately Compatible	Very Compatible	Extremely Compatible

26. Has your center implemented any of the practices that were observed during the site vi
○ Yes ○ No ○ I don't know

CONSULTANTS

27. To what extent has the consultant's visit been useful in considering new practices at your center? (Circle one of the responses below.)

Not at all Useful	Slightly Useful	Moderately Useful	Very Useful	Extremely Useful

28. What aspects of the consultant's visit were most and least useful? How could the visit be improved? Please be specific.

SOURCE BOOK

29. How did you use the Source Book of Programs: Community Mental Health Centers? (Mark only one answer.)
    ○ Read ten or more descriptions
    ○ Read fewer than ten descriptions
    ○ Glanced briefly but have not read any descriptions
    ○ Have never seen it

30. Did the Source Book of Programs provide any ideas which were new at your center?
    ○ Yes ○ No ○ I don't know

31. To what extent has the Source Book of Programs been useful in suggesting new practices for your center? (Circle one of the responses below.)

Not at all Useful	Slightly Useful	Moderately Useful	Very Useful	Extremely Useful

32. What aspects of the Source Book are most and least useful? How could the Source Book be improved? Please be specific.

PLANNING FOR CHANGE

33. How did you use the booklet Planning for Change? (Mark only one answer.)
    ○ Read booklet and discussed change process with staff
    ○ Read booklet but did not discuss it
    ○ Glanced briefly
    ○ Have never seen it

34. To what extent has Planning for Change been useful in considering new practices at your center? (Circle one of the responses below.)

Not at all Useful	Slightly Useful	Moderately Useful	Very Useful	Extremely Useful

35. What features of Planning for Change are most and least useful? How could Planning for Change be improved? Please be specific.

APPENDIX E - Interview Checklists

Meeting with Director

_____ Explain the overall project
_____ Present the *Source Book*
_____ Present *Planning for Change*
_____ Explain site visits and $500 limit
_____ Find out what the center has already planned regarding the visits
_____ Discuss program development procedures used at the center
_____ Discuss together the scope of your visit

Meeting with Liaison Person

_____ Explain the overall project
_____ Present the *Source Book*
_____ Present *Planning for Change*
_____ Explain site visits and $500 limit
_____ Explain liaison person's specific responsibilities
_____ Remind liaison person of continued effort to get center to consider systematic change

Meetings with Key Staff

_____ Explain the overall project
_____ Present the *Source Book*
_____ Present *Planning for Change*
_____ Discuss the center structure
_____ Discuss staff reactions, i.e. awareness, willingness
How do they perceive the center's
    _____ Needs
    _____ Problems
    _____ Resources
_____ Discuss what they would like to accomplish in the group meeting

Group Staff Meeting

_____ Explain the project

_____ Mention Source Book and Planning for Change

_____ Define the general purpose of the meeting

_____ Define the site visits

    _____ Purpose
    _____ Have they decided who will make the trips?
    _____ How did they decide?
    _____ Have they considered places to visit?
    _____ Have they considered what to do once they get there?
    _____ How does the group plan to use the information when the observer returns?

_____ Discuss program planning

    _____ Help center staff develop an awareness of alternative programs
    _____ Encourage staff involvement in considering new programs
    _____ Assist the staff in identifying their needs
    _____ Encourage staff to identify their resources and limitations
    _____ Suggest alternative programs related to their needs, resources and limitations
    _____ Utilize Planning for Change in suggesting future steps

_____ Suggestions on how to implement

    _____ Discuss goal setting
    _____ Suggest a trial run or pilot study
    _____ Need for evaluating pilot study
    _____ Describe how to evaluate--example Goal Attainment Scaling

_____ Try to get commitment to further action

Meeting with Observer

_____ Review goals of site visit

_____ Explain limits of project responsibility

_____ Procedures to follow

    _____ Check choices with AIR

    _____ Arrange visit

    _____ Report to home center staff

_____ Logistics

Final Interview with Director

_____ Review accomplishments of visit

_____ Summarize conclusions about travel plans

_____ Review limitations and treatment details

_____ Try to get the director's cooperation in seeing the group meets upon the return of the observer, and that the center considers the results of his visit.

_____ Ask the director for reactions to our visit

    _____ How did our presence affect the staff, the center, etc.

_____ Remind him that the staff and himself have been asked to return questionnaires within a week, and that the post-treatment questionnaire will be sent in approximately eight months

Second Group Meeting

If a core staff group can meet on the second day, we would like to continue the discussion of what to do once the observer returns.

_____ Review the accomplishments of the previous day

_____ Try to begin a discussion about what they see as the next steps

_____ Ask if there are any specific areas where we might be of help

_____ Refer the group to Planning for Change and go through the steps

Director

1. Explain the Overall Project

- AIR & NCCMHC cooperating in project on information exchange
- Goal is to create an openness to change, to promote the trial of promising innovations
- Methods we're using to accomplish this
  - Source Book and Planning for Change
  - Visits to other centers
  - Consultant assistance
- AIR/NCCMHC team is there to work together with the centers. Not there to lecture. They will fit in however would be best for the center.
- We want director to understand what the project means at his center and to answer his questions
  - We'll be there for two days, talking to staff members individually and in a group
  - Help them decide on trips, who will go, where to go, etc.
  - We'll ask them to fill out a questionnaire now evaluating our visit, and another in about six months
  - We would like the center to be willing to consider using some of the information provided by the project, i.e., we hope that some things suggested by the site visitor would be considered for implementation and that the group might participate to some extent in this process
  - Liaison person for us to interact with should the director be too busy

2. Find out about program development procedures used at that center

- What planning procedures are currently used?
- Does the staff group usually participate in considering new ideas?
- Is the center generally open to change?
- Have individual staff members ever suggested ideas in the past?

3. Present the Source Book

- Purpose is to increase awareness of what's happening elsewhere, to alert centers to what other places are doing
- It is organized in sections roughly grouped around general topics
- Several descriptions are included in each section, each description having the following sections:
  - Purpose
  - Procedures
  - Personnel
  - Costs
  - Outcomes and Evaluation
  - Further Information

- The indices are to help the user find information that might be arranged differently from our major categories
- Explain the flexibility of the book -- pages can be removed or substituted, others can be inserted, sections can be rearranged to make the book more useful.

4. Present Planning for Change

- Its purpose is to help centers as they consider change
- The booklet is designed to be readable and practical; it is not a scholarly review
- Techniques suggested in Planning for Change are appropriate both to the center as a whole and to individuals who want to modify their present methods.
- It has four main sections:
  - Analysis
  - Goal Definition
  - Action
  - Follow-Through

  These sections present the general sequency of activity, even though the activity rarely falls into discrete sections.
- The sections are each organized around the A VICTORY acronym. A VICTORY represents factors that should be considered at virtually any point during the change process. These are Ability, Values, Information, Circumstances, Timing, Obligation, Resistances and Yield.

5. Explain the site visits in more detail

- Have they considered at all what types of programs they would like to know more about?
  - How did they decide on those areas?
  - Are there other areas of interest?
- Does the center have a priority of needs?
  - Have they ever considered their needs?
  - Do their needs match the areas they want to visit?
- Who is going to make the visits?
  - How did they decide on this?
  - Is the staff in general agreement?
- Have specific programs at specific centers been identified?
  - How did they hear about them?
  - Are there several programs all of the same general type, or are they of several different kinds?
- Do they understand the financial constraints and geographical limits?
  - $500 limit for expenses
  - No salary paid by us
  - Visits to occur in their own or neighboring NIMH regions
- The site visitor is to return and inform the rest of the staff about what he's observed. The staff will be asked to make some decision -- either to implement the idea in toto, to take part of it, or not to use it at all.

- Liaison person to take responsibility on carrying through with these steps
    - Will director support it?
    - The group that meets in the afternoon is called a staff advisory group. Is it appropriate for it to act like that?

Contingent on the director's feelings, we want to follow through on who is going to be responsible for the visits, and what's going to be done.

How does the director feel about getting staff involved? Does he favor involving the group directly in a decision or would he prefer indirect means (have the groups make suggestions to him)?

Point out that we realize the director is ultimately responsible for the center and will have to decide on any suggestions. We also realize that staff involvement is important so we want to include them in this whole process, but we're not trying to take control away from director. We would like to talk in the group about needs and alternatives.

Meeting with Liaison Person

Explain the overall project (see Director form)
Present the Source Book (see Director form)
Present Planning for Change (see Director form)
Explain the site visits (see Director form)

Specific responsibilities:

- Notify AIR of sites your center would like to visit
- Inform visitors when O.K. is received
- Assist visitors in making travel plans if necessary
- See that report of visit (including implications for your center) is presented to as many of the staff as possible
- Encourage your center to consider using the information
- Remind staff of Planning for Chcnge
- Inform AIR of decision made regarding use of information from site visits
- See that evaluation questionnaires are returned by staff
- Remind liaison person of continued effort to get center to consider systematic change

Staff Meeting

1. To help center staff develop an awareness of alternative programs

   - Explain the programs described in the Source Book (See "Present the Source Book")

2. To encourage staff involvement in considering new programs

   - One of the reasons for the group meeting is to facilitate interaction among staff. These people with busy schedules are together for at least an hour to focus on program development and planning to think about what's happening at other centers, and to pick what they can use at their center or in their own work.
   - Their involvement here should help demonstrate the importance of personal contact. We hope to spread this still more by having them explain to other staff members what we are about, and by helping them realize the importance of personal contact when their staff member goes to visit other centers.

3. To assist staff in identifying their needs

   - Ask staff whether the center already has determined a priority of needs
   - If not, try to get discussion and agreement on needs.

   Questions that might be used:
   - Are there any immediate needs or concerns that you feel the center should try to deal with more adequately?
   - In terms of long-range goals, in what areas should the center put more of its resources?
   - What have you tried already? What were the problems and why?

   The director specified what he felt the needs of the center were. These needs could be mentioned, though it may not be necessary to say that they represent the director's views.
   - What programs might be effective at your center that are not being done now?

4. To encourage staff to identify their resources and limitations

   - Once the needs are verbalized, how do they compare with what the center has to work with?
   - Try to get discussion on resources

   Resources might be such things as:
   - Community support
   - Within budgetary limitations
   - Adequate staff
   - Capable staff

- Support from the administration
- Adequate buildings and rooms for meeting; facilities
- Good equipment
- Consultant support
- Active volunteer force
- Enthusiasm among staff
- Well-run center with good communication
- Seed money available for new programs
- Supportive professional organizations
- Travel allowances
- Other agencies in the community
- Inservice training
- Staff cooperation

Question to stimulate discussion:
- What do you consider to be the strengths of your center?

Limitations would be the absence of these features or else their presence in a limited scope.

Question to stimulate discussion:
- What do you consider to be the weaknesses of your center?

5. To suggest alternative programs related to these needs, resources and limitations

- Summarize what staff has identified as needs, resources and limitations
- Direct group's attention to appropriate section of Source Book; ask them to peruse the descriptions to see if any seem appropriate
- Mention other programs which the NCCMHC/AIR team is aware of and that might be of interest to this center
- Ask group if they have other innovative programs in mind that are not included in the Source Book
- Try to get a discussion of the pros and cons of various programs
- Encourage the group to order those they would like to know more about
- Point out that the visits can be made as the center prefers -- one or two people can make a joint trip, the whole staff can made a shorter visit, or two people can visit several other centers
- We prefer at least two staff members going together to observe a program elsewhere. This is more effective since they will return and encourage each other as well as the rest of the staff.
- Programs to be visited are to be chosen by the staff. If more than one program is visited, they can be programs in the same or different general areas. Sites must be within geographical and financial limits to be covered by this project.
- Direct the group's attention to choosing who will be making the trip
- Those most directly involved, i.e., actually working, should be the ones sent to observe

- Encourage the group to make a selection at this meeting. If it is impossible, establish the procedures that will be used, and the time limits.
- Do they want different people to visit different programs?

6. To utilize Planning for Change in suggesting future steps the center might take and suggestions on how to implement.

   - Once the visitor returns and reports, then what?
   - Call attention to the ACTION section of Planning for Change
   - Involve staff in planning
   - Consider how your center will react to the new program
   - Decide on your own resources -- money, etc.
   - Respond to staff reactions.

7. Try to get a commitment to future action

   - Try to get the group to consider what their next step should be.
   - Who will be responsible for convening the group?
   - How will a decision be made?
   - Will this group come up with recommendations and submit them to some other group, or can their recommendations be implemented?
   - If they decide to implement, who will take responsibility?
   - Point out that these changes need not be system-wide. They may decide to adapt an idea and add it to an already existing program. In this case, the program director would already be identified. If it is a minor change, this group may not be the appropriate channel for dealing with it. Or maybe some other system is already in existence and no variation is appropriate.

8. Evaluate our visit

   - At the close of the meeting, distribute questionnaires to staff. Ask personnel to fill them out and return them as soon as possible in the enclosed envelope.
   - Alert staff to the fact that long-range evaluation questionnaires will be coming in about eight months, and request their cooperation in completing them and returning them to us.

APPENDIX F - Data Collection Form (Innovator Questionnaire)

AMERICAN INSTITUTES FOR RESEARCH

SOCIAL AND EDUCATIONAL RESEARCH PROGRAM

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Center ______________________________ Telephone Number ______________

Name ____________________________ Title ____________________ Degree ________

If some of the following questions can be answered from material you are sending, simply write i a reference to the appropriate material.

Title and Brief Description of the Practice:

Purpose: (What are the goals of this practice?)

When was the practice introduced?

Who introduced it and why?

Approximately how many clients are involved at any one time? (If applicable)

mailing: P.O. BOX 1113, PALO ALTO, CALIFORNIA 94302 (LOCATION: 1791 ARASTRADERO ROAD) • TEL. (415) 493-3550

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Procedures: (Describe organizational details, actual procedures, and any special facilities or equipment which are required. Please be specific and detailed in this section.)

Staff: (List number and titles of staff and the amount of time they spend on this practice. Describe any special duties or responsibilities.)

Describe special training for staff if any was required to institute new practice.

Costs: (List types of expenses and describe sources of funds. Include available information on estimates of total cost during a certain period of time and, if possible, a rough breakdown of the costs into components.)

Procedures: (Describe organizational details, actual procedures, and any special facilities or equipment which are required. Please be specific and detailed in this section.)

APPENDIX G - Innovations Questionnaire

Number of questionnaires tallied = 154 Fall 1973 issue

INNOVATIONS

1. Do you ever think, "Maybe other mental health agencies would be interested in the way we've handled this problem?"

133 As a matter of fact, I have.

8 You must be kidding!

2. If you have, have you ever written up an innovative solution for publication?

94 No

47 Yes. Where did you submit it?

Was it published? No = 10 Yes = 25

3. Do you ever think, "I wish I knew what other mental health agencies have done about this problem?"

101 Have I ever!

48 Occasionally

1 Not really

4. If Yes, do you have any way to find out?

42 No

102 Yes. How? Personal contact: 60

Print: 45 Write for info: 8

5. What articles in the current issue of Innovations appealed to you most?

	WHY		
Name of Article*	It was useful	I enjoyed reading it	Other reasons
Alternatives (Weber & Sacto)	55	51	7
Dialogue	22	27	2
Innovations Now	28	18	4
Case Study	31	25	4

6. What about the appearance of the magazine? In general, did you find it:

pleasing	71	51	16	7	1	not pleasing
different	51	39	37	11	1	not different
good	62	54	19	6	1	bad

7. How about the way the articles were written? Did you think the articles were:

interesting	80	51	16	1	1	boring
understandable	94	48	4	-	-	not understandable
technical language	5	19	33	34	32	popular language

Others received
0 or fewer
entions

8. Do you wish articles gave more how-to-do-it information?

56 Yes, definitely.
51 A bit more.
37 No, I like the articles as they are.

9. If you saw Innovations on a colleague's desk, would you:

	Probably	Maybe	No
pick it up and look at it?	111	19	3
borrow it and read it?	79	40	9
try to get your own copy?	96	30	9

10. In future issues, I'd like to see articles about:

11. How about the amount of space given to our departmental features? Should these departments:

remain as is	be expanded	be shortened	be dropped	
78	37	9	2	Dialogue (p. 17)
62	62	2	–	Innovations Now (p. 28)
68	35	18	7	Books (p. 32)
62	47	8	2	Looking Forward Legislatively (p. 35)
70	43	8	4	Short Cuts (p. 36)

12. Do you have other comments or suggestions?

13. How about you:

Your Name: ______ Agency: ______
What is your job? ______
Your education? ______

14. Would you like to add someone's name to our mailing list to receive Innovations?

Name ______ Agency ______
Address ______
______ Zip ______

Name ______ Agency ______
Address ______
______ Zip ______

Types of respondents:

Agencies represented	
CMHC/Guidance centers	56
State hospitals	20
Other hospitals	14
Faculty	29
Other	27

Job level of respondent	
Supervisorial/administrative	67
Inservice education	9
Faculty	23
Counseling/social work	20
Health services	7
Other	14

Education	
Some college	1
4-year college	7
Master's	70
Ph.D.	37
M.D.	11
Other	6